MAGELLAN MEDICAID ADMINISTRATION

Hospital, Inpatient

Provider Type 11 Billing Guide

Program Overview

A hospital is an inpatient medical facility that provides services at an acute level of care for the diagnosis, care and treatment of human illness, primarily for patients with disorders other than mental diseases. For purposes of Medicaid policy, a hospital does not include Institutions for Mental Diseases (IMDs), Nursing Facilities (NFs) or Intermediate Care Facilities for the Mentally Retarded (ICF/MRs).

See MSM Chapter 200 for additional policy and guidelines.

Managed Care vs. Fee For Service

When a recipient is enrolled in a Managed Care Organization (MCO), request prior authorization from and submit claims to the MCO.

When a recipient is enrolled in the Fee For Service (FFS) plan, request prior authorization from and submit claims to Magellan Medicaid Administration.

Rates

Rate information is on the DHCFP website at http://dhcfp.nv.gov (select "Rates" from the DHCFP Index at left).

Non-covered Services

The following items are common services/conditions that are not covered by Medicaid. Refer to MSM Chapter 200, for a complete list of non-covered services.

- Observation that exceeds 48 hours (code G0378). Also non-covered are any ancillary services provided as part of observation after the 48-hour policy limit.
- Admission from the community, another facility, a physician's office, an ER or observation directly to an administrative level of care.

Authorization

Claims will be denied if proper authorization is not obtained. See MSM Chapter 200, section 203 for complete authorization requirements.

Authorization is valid only for the date(s) specified. If the corresponding claim includes unauthorized dates of service, services provided on those dates cannot be paid.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Requesting Authorization

To request authorization:

- Complete and fax form FA-3 or FA-8 as appropriate to Magellan Medicaid Administration; or,
- Use the Online Prior Authorization System (OPAS) to complete/submit required information online.

Authorization requests must be received within the timeframes listed below.

- **One business day** if the recipient was Medicaid-eligible on the date of service.
- **Five business days** if the recipient was not Medicaid-eligible upon admission, but obtained retroactive eligibility during their stay.

  If a recipient has been in the hospital for over 30 days when retroactive eligibility is determined, providers must:
  - Submit clinical information in (at least) 30-day increments **and**
  - Provide a weekly summary of the treatment plan for the date range(s) submitted.
- **Ninety calendar days** from the date of decision if the recipient obtained retroactive eligibility after discharge.
- **Concurrent authorization requests** must be received by the end date of the current/existing authorization period. If a concurrent authorization request is not

received within this timeframe, a second authorization period, if clinically appropriate, can begin on the date Magellan Medicaid Administration receives a concurrent authorization request. Nevada Medicaid will not pay for unauthorized days between the end date of the first authorization period and the begin date of a second authorization period.

If Magellan Medicaid Administration **requests additional clinical information** to complete an authorization request, the additional information must be submitted within five days of request or a technical denial will be issued.

After receipt of complete information, **Magellan Medicaid Administration will notify the provider** of a determination within one business day for eligible recipients and within 30 days for discharged, retro-eligible recipients.

Additional clinical information that may alter the determination can be submitted to Magellan Medicaid Administration within five business days of the determination. This is called requesting '**reconsideration**.'

Magellan Medicaid Administration's determination is based on clinically appropriate standards and may include approval, denial or level of care adjustment.

Services That Require Authorization

See MSM Chapter 200, Section 203.1A (2) for a complete list of services that require authorization.

Examples of services requiring prior authorization include:

- Any surgery, treatment or invasive diagnostic testing unrelated to the original reason for admission; or days associated with unauthorized surgery, treatment or diagnostic testing.
- Nonemergency admissions.
- Changes in level of care and/or transfer between hospital units, except a change between medical/surgical and intensive care.

Allow up to 2 business days for response to admission (e.g. nonemergent, elective, dental, family planning), nonemergent transfers, and therapeutic pass authorization requests.

Examples of services that must be **authorized within one business day** of admission include:

- **Emergency admissions or transfers** from one acute inpatient hospital to another (receiving facility's responsibility for transfers).
- Admissions initiated through emergency or observational when a physician writes the inpatient admission order.
- Hospital admission for Medicare Part A recipients after their **Medicare benefits are exhausted**. Reference Section 203.1.A in MSM Chapter 200.
- **Obstetric or newborn admissions:** 1) that, from the date of admission, exceed 3 calendar days for vaginal or 4 calendar days for elective or emergency cesarean delivery or 2) when delivery occurs or fetal demise during delivery occurs immediately prior to hospital admission. (See "Prior Authorization Requirements for Obstetrical Hospital Admissions" on last page.).
- Newborn admissions to **NICU**.

Acute Inpatient Admissions

Each request for acute inpatient admission must include specific pertinent medical information that substantiates that an acute inpatient admission meets both severity of illness and intensity of service requirements.

Reconsideration, Peer-to-Peer Review and Fair Hearings for Acute Inpatient Admissions

If a combination of severity of illness and intensity of service criteria for inpatient admission is not presented in the authorization request submitted to Magellan Medicaid Administration, the hospital provider, along with the attending physician, is encouraged to participate in a peer-to-peer review with Magellan Medicaid Administration's physician reviewer.

In preparation for a peer-to-peer review, the provider is responsible for obtaining from the attending physician, additional information regarding medical justification that supports the need for inpatient services and the position that care can not be effectively rendered at a lower level of care.

If proper medical justification is not provided to Magellan Medicaid Administration in an initial/continued stay request, a peer-to-peer review, and/or a reconsideration review this demonstrates failure of the provider to comply with proper documentation requirements. New information will not be accepted at a hearing preparation meeting or during a Fair Hearing.

If proper documentation is not submitted as described above, the authorization request will not be considered by Magellan Medicaid Administration at any later date.

Newborn and/or Neonatal Intensive Care Unit (NICU) Admissions Using Revenue Codes 0173 and 0174

Prior authorization must be requested using the newborn's Recipient ID.

- If the newborn does not have a Recipient ID when admitted, but receives one during their stay, prior authorization must be requested **within five business days of the date of eligibility decision**.
- If the newborn receives a Recipient ID after discharge, a retroactive authorization request must be submitted **no later than 90 calendar days after the newborn is assigned a Recipient ID**.

Family Planning Admissions

Refer to Sections 603.3 and 603.4 in MSM Chapter 600 for requirements.

Non-Emergent Transfers

The provider who initiates a recipient's non-emergent transfer from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, rehabilitation, specialty) is responsible for requesting prior authorization before the transfer.

The receiving hospital is responsible for verifying that the transferring provider obtained authorization for a non-emergent transfer prior to agreeing to accept/admit the recipient and prior to the transfer.

Oral and Maxillofacial Surgery

Two prior authorizations are required: one for the procedure and a second for the admission.

Special Billing Instructions

Please refer to the UB Claim Form Instructions to complete your claim.

An Authorization Number issued by Magellan Medicaid Administration must be entered on the UB-04 claim in Field 63A, B or C, as appropriate.

Emergency Room

Emergency room services resulting in a direct inpatient admission in the same facility as part of one continuous episode of care are included in (rolled into) the inpatient hospital per diem rate for the date of admission, even if the emergency services are provided on the calendar date preceding the admission date. Do not bill outpatient emergency services in addition to the inpatient per diem rate.

Persons Eligible for Emergency Services Only

For persons eligible for emergency services only, Nevada Medicaid covers services to stabilize the sudden onset of an emergency medical condition— services provided before the emergency or provided after the emergency has been stabilized are not covered.

For these persons, Medicaid does not cover:

- Nonemergent or elective services.
- Services for an existing, underlying, chronic condition.
- Services once an emergency medical condition is stabilized or in the absence of an emergency medical condition.

The Emergency Room Code List provides a list of emergency services that may be paid for persons who are eligible for emergency services only (at http://nevada.fhsc.com, select "Procedure and Diagnosis Reference Lists" under the "Prior Authorization" menu).

Direct Admissions from Observation

When there is a direct inpatient admission from observation, the inpatient hospital per diem rate includes all observation/ancillary services that occur in the same facility as part of one continuous episode of care beginning on the same calendar date the physician writes the inpatient admission order.

Do not bill observation hours and ancillary service in addition to the inpatient per diem rate on the same calendar date.

Observation and ancillary services rendered on a calendar date preceding the rollover inpatient admission date may be billed as outpatient services.

Please refer to the Billing Guide for Provider Type 12, Hospital Outpatient.

Administrative Days

Use revenue codes 0160 and 0169 to bill for administrative days, as applicable. At least one acute inpatient hospital day must immediately precede an administrative level of care day.

For requirements on requesting concurrent authorization, please see the "Requesting Authorization" section beginning on page 1in this document.

Maternity

Submit two claims for maternity services: one for the newborn and a second for the mother. On claims for services provided to newborns, use the newborn's 11-digit Recipient ID. (The newborn must have a Recipient ID before a claim for the newborn can be submitted.)

When billing for maternity services that do not require prior authorization, include both an **ICD-9 procedure code and an ICD-9 diagnosis code** on your claim.

Tubal Ligation

When a tubal ligation is performed at the time of obstetric delivery, be sure to submit a Sterilization Consent Form with your claim. Failure to provide this form will result in claim denial. For additional requirements, see "Sterilization and Abortion Policy."

Psychiatric/Detoxification

Any acute inpatient days authorized at a psychiatric/detoxification level of care must be billed separately from days authorized at a medical/surgical/ICU level of care. Refer to MSM Chapter 400, Section 403.9 for additional information.

Swing Beds ("Medicare Certified" in Rural or Critical Access Hospitals Only)

Swing-bed days are billed on a UB-04 claim form using the hospital's National Provider Identifier (NPI).

Use Type of Bill code 0281 in Field 4 on the claim form. Use revenue code 0550 to bill for skilled days when swing bed days are authorized. Therapy, laboratory and radiology services can be billed by independent service providers.

Swing beds can be billed on an all inclusive claim form after the date of discharge for stays of less than 30 days and should be interim billed, month to month, for stays over 30 days.

Discharge Day

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

Leave of Absence

Providers must notify Magellan Medicaid Administration and, when applicable, obtain prior authorization for a leave of absence that exceeds eight hours or involves an overnight stay. Bill the inpatient day(s) related to the leave of absence according to the authorized revenue code.

Admit/Discharge/Death Notice

Submit the Admit/Discharge/Death Notice (form 3058-SM) to the local Division of Welfare and Supportive Services District Office whenever a hospital admission, discharge, or death occurs. Failure to submit this form could result in payment delay or denial.

Prior Authorization Requirements for Obstetrical Hospital Admissions

Vaginal Delivery	Day Prior to Delivery	Day of Delivery	First Post Partum Day	Second Post Partum Day	Third Post Partum Day	Fourth Post Partum Day
Normal	n/a	Covered at maternity level. Prior authorization not required.			n/a	n/a
With complications that require a stay of more than 3 days	n/a	Request prior authorization for 3 maternity-level days and 1 acute med/surg level day.				n/a
Induced labor with or without complications that require a stay of more than 3 days	n/a	Request prior authorization for 3 maternity-level days and 1 acute med/surg level day.				n/a
With active labor that meets acute level of care criteria prior to the day of delivery	**Call Magellan Medicaid Administration at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and 3 maternity-level days.				n/a	n/a
With active labor that meets acute level of care criteria prior to the day of delivery and medical complications after delivery that require a stay of more than 3 days	**Call Magellan Medicaid Administration at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and up to 4 normal maternity days. **If additional days meet acute med/surg level of care criteria**, call Magellan Medicaid Administration again to request that the additional days be added to the authorization.					n/a
Cesarean Delivery	**Labor**	**Day of Delivery**	**First Post Partum Day**	**Second Post Partum Day**	**Third Post Partum Day**	**Fourth Post Partum Day**
Normal	n/a	Covered at maternity level. Prior authorization not required.				n/a
With complications that require a stay of more than 4 days	n/a	Request prior authorization for 4 maternity-level days and 1 acute med/surg level day.				
With complications during labor that met acute level of care criteria	**Call Magellan Medicaid Administration at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and up to 4 normal maternity days.					n/a
With active labor that meets acute criteria prior to the day of delivery and medical complications after delivery that require a stay of more than 4 days	**Call Magellan Medicaid Administration at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and up to 4 normal maternity days. **If additional days meet acute med/surg level of care criteria**, call Magellan Medicaid Administration again to request that the additional days be added to the authorization.					