Hospital, Outpatient

Outpatient Hospital Policy

General medical/surgical hospitals commonly provide outpatient services, including but not limited to:

- Clinic, office, emergency room (ER) and urgent care
- Observation, laboratory, radiology, therapy and diagnostic services
- Simple, surgical procedures using local anesthetic or moderate sedation

Complete outpatient hospital services policy pertaining to **facility responsibility** is located in Medicaid Services Manual (MSM) Chapter 200. This chapter and all other MSM chapters are on the Nevada Medicaid website, nevadamedicaid.nv.gov.

Outpatient hospitals are responsible for referencing MSM chapters applicable to the type of services provided.

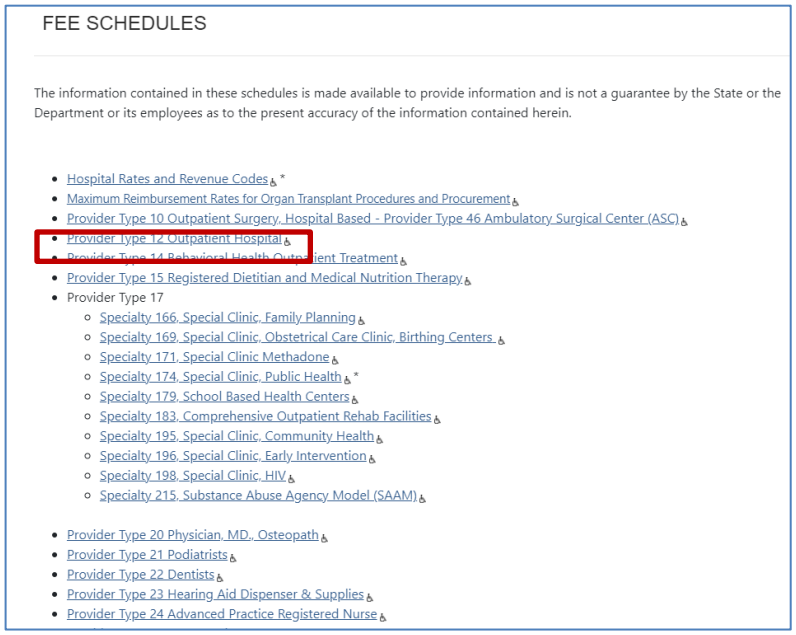
Examples of other MSM chapters containing provider responsibility and authorization requirements for services provided in an outpatient hospital include, but are not limited to:

- Chapter 300 - Diagnostic Testing and Radiological Services
- Chapter 600 - Physician and licensed professionals' responsibilities and some procedures performed in an outpatient hospital (e.g., wound, burn and diabetic care) and ER policy.
- Chapter 800 - Laboratory Services
- Chapter 1200 - Prescription/Infusion Services
- Chapter 1700 - Therapy Services
- Chapter 1900 - Transportation

Other Resources

MSM Chapter 100 provides general Nevada Medicaid policy regarding eligibility, coverage and limitations. This chapter contains important information applicable to *all* provider types.

For **reimbursement rates**, see the *Provider Type 12: Outpatient Hospital Rates* document on the Rates page of the Nevada Medicaid website. Rates are also available on the Provider Web Portal at medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the PWP Login webpage under Resources (you do not need to log in).


FEE SCHEDULES

The information contained in these schedules is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein.

- Hospital Rates and Revenue Codes *
- Maximum Reimbursement Rates for Organ Transplant Procedures and Procurement
- Provider Type 10 Outpatient Surgery, Hospital Based - Provider Type 46 Ambulatory Surgical Center (ASC)
- Provider Type 12 Outpatient Hospital
- Provider Type 14 Behavioral Health Outpatient Treatment
- Provider Type 15 Registered Dietitian and Medical Nutrition Therapy
- Provider Type 17
  - Specialty 166, Special Clinic, Family Planning
  - Specialty 169, Special Clinic, Obstetrical Care Clinic, Birthing Centers
  - Specialty 171, Special Clinic Methadone
  - Specialty 174, Special Clinic, Public Health *
  - Specialty 179, School Based Health Centers
  - Specialty 183, Comprehensive Outpatient Rehab Facilities
  - Specialty 195, Special Clinic, Community Health
  - Specialty 196, Special Clinic, Early Intervention
  - Specialty 198, Special Clinic, HIV
  - Specialty 215, Substance Abuse Agency Model (SAAM)
- Provider Type 20 Physician, MD., Osteopath
- Provider Type 21 Podiatrists
- Provider Type 22 Dentists
- Provider Type 23 Hearing Aid Dispenser & Supplies
- Provider Type 24 Advanced Practice Registered Nurse

Hospital, Outpatient

The Nevada Medicaid provider website at medicaid.nv.gov provides information on many subjects including provider training, billing, pharmacy, PA, provider appeal rights related to claim and PA determinations, and PA reconsiderations.

Refer to the "ICD-10-CM Emergency Diagnosis Codes for Non-U.S. Citizens with Emergency Medical Only Coverage" document for services related to complications of pregnancy, childbirth, puerperium and outcome of delivery V codes that may be paid for persons eligible for emergency services only. This list also includes diagnoses related to the provision of outpatient emergency dialysis through the Federal Emergency Services Program. **Note:** Use ICD-10 codes on claims with dates of service on or after October 1, 2015.

Prior Authorization (PA)

All program limitations for services apply (e.g., therapy, wound care, diabetic training or minor surgeries).

Emergency acute hospital admissions directly from ER require authorization within five business days of the date of admission.

A PA is required for acute hospital admission from outpatient observation status before admission. If an emergency develops during observation, the emergency admission rules apply.

Transplants: Submit outpatient medical/surgical authorization requests as soon as the recipient is placed on a wait list and include PT 12 or PT 20 as the rendering provider and the transplant CPT code. Dates of service requested will be 365 days. This request will be reviewed for medical necessity of the service.

Once the organ is available and the recipient is admitted to the hospital, an inpatient medical/surgical authorization request must be submitted to cover the inpatient stay.

To determine if authorization is required, refer to the Medicaid Services Manual that is specific to the service being provided, and the Fee Schedules. Providers may also search criteria for PA requirements by selecting Authorization Criteria from the Provider Web Portal Login (PWP) page (see Web Announcement 867 for access tips). To request PA, complete the appropriate form for the service being requested. Prior authorization forms are located on the Providers Forms webpage. Submit the form through the online prior authorization system (log in to the Nevada Medicaid provider website, medicaid.nv.gov, and select "Provider Login (PWP)" from the PWP tab).

If Nevada Medicaid requests additional information to complete a PA determination, the information must be submitted within *five business days*.

An approved PA is valid for the dates of service shown on the authorization. If service cannot be provided within the authorized dates, the PA becomes invalid and the provider must obtain another authorization that reflects the proper service dates.

Any service requiring PA that is not prior authorized will be denied for payment.

An approved PA does not guarantee claims payment. 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.

Managed Care vs. Fee For Service (FFS)

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

For recipients in the FFS plan, PA is requested and payment is issued through Nevada Medicaid.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: medicaid.nv.gov/providers/edi.aspx and the PWP User Manual Chapter 3 located at: medicaid.nv.gov/providers/evsusermanual.aspx

Take-home Drugs

Take-home drugs are billed through the Point-of-Sale (POS) system using the hospital's Pharmacy NPI and the applicable National Drug Code (NDC). Do not include take-home drugs on your 837I claim. See PWP User Manual Chapter 3 Claims for billing instructions.

See MSM Chapter 1200 for Nevada Medicaid coverage and criteria for medications.

COVID-19 Testing

Nevada Medicaid covers COVID-19 diagnostic and serology antibody testing up to twice per rolling month for each recipient. If additional testing is deemed medically necessary, a prior authorization may be submitted.

Code	Description
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), amplified probe technique
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique
87811	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])

Non-emergent use of the ER

Non-emergent use of the ER must be billed at the lowest level ER service code that is appropriate, either 99281 or 99282.

Emergency Department (ED) Rollover Admissions

ED 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 day per diem rate for the date of admission, even if the emergency services are provided on the calendar date preceding the admission date.

Behavioral health related admission to hospitals with or without a Psychiatric Unit or Alcohol/Substance Use Treatment Unit requires a psychiatric assessment to determine medically necessary treatment delivered in the appropriate setting. Assessment services may be billed separately from the inpatient psychiatric stay when they are performed in the hospital emergency department by an outside entity within their scope of practice; this does not include physicians and other qualified health care providers who are hospital staffed.

Mental Health Services in the ER

Recipients that require mental health services while in the ER may receive such services if medically appropriate. As soon as the recipient is stabilized, every effort must be made to transfer the recipient to a psychiatric hospital or unit, accompanied by a physician's order.

Justification for all services and transfers must be documented in the recipient's medical record.

Biofeedback Services

Nevada Medicaid covers code 90901 (Biofeedback training by any modality) for up to 6 units per a 4-week period. If additional services are medically necessary, providers may submit a request for prior authorization. This code applies to any of several modalities of biofeedback training used for treatment of conditions including, but not limited to, high blood pressure, incontinence, Raynaud's syndrome, and anticipatory nausea due to chemotherapy.

Please note, codes 90875 or 90876 should be utilized for Individual psychophysiological therapy incorporating biofeedback training by any modality. These codes should be billed when the treating clinician gives individual psychophysiological therapy by utilizing biofeedback training together with psychotherapy to modify behavior. Please see the PT 14 billing guide for more information.

Breast Pumps & Supplies

Breast pumps and supplies are covered in an Outpatient Hospital setting for **Nursing Mothers with infants up to 12 months of age**. The hospital is able to provide these items to Nevada Medicaid recipients and be reimbursed for the following codes:

Code	Description	Service Limitations	PA
E0602	Manual Breast Pump Rental or Purchase	RR (rental) – 1 unit per mo for 10 mos NU (purchase) – 1 unit per 3 yrs	PA required when service limitations are exhausted
E0603	Electric Breast Pump Rental or Purchase	RR (rental) – 1 unit per mo for 10 mos NU (purchase – 1 unit per 3 yrs	PA required when service limitations are exhausted

Code	Description	Service Limitations	PA
E0604	Hospital Grade Breast Pump rental only	RR (rental) – 1 unit per mo up to 6 mos	PA Required
A4287	Disposable collection and storage bag for breast milk	200 units per 30 rolling days	PA required when service limitations are exhausted

Non-U.S. citizens eligible for emergency medical only coverage

For non-U.S. citizens eligible for emergency medical only coverage, only services to **stabilize the sudden onset** of an emergency medical condition are reimbursed.

A *sudden onset* emergency medical condition does not include:

- Non-emergent 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.

Observation

Refer to MSM Chapter 200, Attachment A, Policy #02-04, for observation policy requirements.

Only use HCPCS code G0378 to bill for hourly observation services. Ancillary services provided during observation hours can also be billed.

Observation is limited to 48 hours. Do not bill for observation hours exceeding the 48-hour policy limit. Ancillary services provided beyond the 48-hour observation limit can be billed if not in conjunction with billed observation hours exceeding the 48-hour limit.

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* a rollover inpatient admission date can be billed as outpatient services up to the 48-hour policy limit.

End Stage Renal Disease Services

Effective with claims with dates of service on or after April 6, 2015, hospital providers must bill outpatient ESRD services under provider type 81 (Hospital Based ESRD Provider). Provider type 12 will no longer be reimbursed for hospital based outpatient ESRD services. Any hospital based ESRD services not billed with provider type 81 will be denied. Please see the Billing Guide for provider types 45 and 81 for billing instructions.

Smoking/Tobacco Cessation Counseling

Current Procedural Terminology (CPT) codes 99406 (Smoking and tobacco use cessation counseling visit, intermediate, 3-10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes) may be used to bill smoking cessation counseling for all Nevada Medicaid recipients. Procedure codes 99406 and 99407 are no longer restricted to counseling for pregnant women only. The limitation for both codes is a maximum of 24 encounters per year. These limitations can be exceeded if determined medically necessary by Nevada Medicaid.

Wound Care Management

For further information on medically necessary wound care applications and skin substitutes, please refer to Medicaid Services Manual (MSM) Chapter 600, Physician Services, Attachment A, Policy #6-02 and to the Nevada Medicaid Fee For Service (FFS) Fee Schedule.

The following skin substitutes are billable and require prior authorization: Q4133, Q4186, Q4101. Either the signed and dated treatment plan or the letter of medical necessity must be uploaded with the Outpatient Medical/Surgical Services Prior Authorization Request (Form FA-6).

The following application codes are billable without a prior authorization: 15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278.

Billing Instructions

Use Direct Data Entry (DDE) or an 837I transaction (for electronic submissions) to bill outpatient hospital services. See PWP User Manual Chapter 3 Claims for billing instructions and the EDI companion guide.

Billed services must match the approved authorization.

Contact Information

If you have any questions regarding PA, please contact the Gainwell Technologies Prior Authorization Department at **(800) 525-2395.**

If you have questions that pertain to billing, please contact the Gainwell Technologies Contact Center at **(877) 638-3472.**