Psychiatric Hospital, Inpatient

Inpatient mental health services are those services delivered in freestanding psychiatric hospitals or general hospitals with a specialized psychiatric and/or substance abuse unit, which include a secure, structured environment, 24-hour observation and supervision by mental health professionals, and a structured multidisciplinary clinical approach to treatment.

Policy

Refer to the Nevada Medicaid Services Manual, Chapter 400 for additional information.

Covered services

Medicaid covered services are rehabilitative in nature and involve restoration of basic skills necessary to function independently in the community. This includes redevelopment of communication and socialization skills, family education and other family services exclusively related to treatment or rehabilitation of the covered individual. Room and board is covered if necessary for psychiatric services. Therapy for marital, parenting or gambling problems with a DSM-IV diagnosis is also a covered service.

Non-covered services

Medicaid reimburses for psychotherapeutic services provided by psychiatrists or psychologists only. Services provided by nurse practitioners, physician's assistants, social workers or marriage and family therapists are not Medicaid covered benefits. Medicaid coverage does not include partial hospitalization, support group services or custodial services.

Prior authorization requirements

Authorization from Nevada Medicaid must be obtained prior to all non-emergent admissions and services. A tentative treatment plan will be required to obtain prior authorization approval.

Initial Review

All requests should be made using the Inpatient Mental Health Prior Authorization (form FA-12) and uploaded to the Provider Web Portal. Requests for the initial stay may not exceed 7 days, except for retrospective reviews. A CASII/LOCUS acuity level of at least 6 is required for hospital admission. A Certificate of Need (CON) must be signed and dated by the physician and must be included with FA-12. FA-12 must include an individualized treatment plan with active participation by the recipient and their family, when applicable. Documentation must include all behavioral health services that have been attempted prior to admission, including name of the provider, services rendered and dates of service.

Concurrent Review

All requests for concurrent review should be made using the Inpatient Mental Health Services Concurrent Review Request (form FA-14) and uploaded to the Provider Web Portal. Requests for concurrent stay may not exceed seven days, except for retrospective reviews. Each prior authorization must stand on its own; therefore, two to three sentences regarding why the recipient was initially admitted is recommended. Generally, this is documented under justification for continued services. As the recipient's acuity level is at least 6, after the initial dates of service there should not be any unspecified diagnoses or remaining rule out diagnoses.

Retrospective Authorizations

If the recipient becomes eligible during their stay, providers must request a retrospective authorization utilizing form FA-12 or form FA-14. If a recipient is currently a patient at the hospital, the provider has 10 business days from the eligibility date of decision to submit the retrospective review. If the recipient has been discharged prior to the eligibility date of decision, the provider has 90 calendar days to submit their retrospective review. When submitting a retrospective authorization, it must be attached to the original prior authorization number which included specific dates of service that

were denied for loss of eligibility, when the recipient's eligibility is reinstated (retrospective). On FA-12 or FA-14, select "Retrospective Authorization" and fill out all other necessary fields. The forms can be located on the Providers Forms webpage at medicaid.nv.gov.

Retrospective Documentation

When submitting for a retrospective review, please only provide pertinent clinical information that would substantiate medical necessity. Voluminous clinical data will not be reviewed and will cause delays in the processing of a request. Level of Care (LOC) and dates of service must be clearly documented. Note that Nevada Medicaid will not reimburse for date of discharge. Admission and discharge summaries by the physician are recommended along with a concise summary of symptoms, behaviors and treatment interventions that have occurred every five to seven days.

Submission Guidelines

Initial requests (form FA-12) must be submitted within five business days after admission for emergency admissions. All other requests must be submitted prior to admission. Concurrent requests (form FA-14) must be submitted within five business days of the last day of the current/existing authorization period. If a concurrent request is not received within the appropriate time frame, a second authorization period, if clinically appropriate, can begin on the date a concurrent authorization is received. Providers are advised not to wait to request a concurrent authorization based on a pending appeal or if the prior treatment period is pending information. Nevada Medicaid will not pay for unauthorized days between the end date of the first authorization period and the begin date of the second authorization period.

Skilled Days

Skilled Days do not need to be denied first at the acute level of care, but can be submitted as concurrent days. If the provider does not appeal an adverse decision, a request can be made for the denied dates of service at a lower level of care. When submitting a reconsideration review, additional days cannot be added at a lower level of care as they were not part of the original denial. Requests for additional days must be submitted separately. Skilled Days will be denied if the recipient was not at an acute inpatient level of care facility at least one day immediately preceding the request for skilled days. Skilled Days will be denied if a recipient, family member or physician refuse to cooperate with the discharge plan or refuse appropriate placement. Skilled Days will be denied if the provider fails to submit evidence of comprehensive discharge planning.

Medicare Eligibility

When submitting a request for a recipient with Medicare Eligibility (Part A), you must include a copy of the Medicare Catastrophic Coverage Act (MECCA) form or other qualifying documentation that demonstrates that the recipient's Medicare days have been exhausted. If Medicare Part A days have not been exhausted, a prior authorization is not needed as the provider would be instructed to bill Medicare Part A. If Medicare denies a stay due to exhausted benefits and no prior authorization was obtained, the provider may submit a retrospective request and mark that it is a retrospective review for Medicare. The retrospective review must be submitted within 30 days of receipt of the Medicare notification or the explanation of benefits (EOB). It is recommended that Medicare be billed as soon as possible after the recipient is discharged.

Admit/Discharge/Death Notice

All hospitals are required to submit Form 3058-SM to their local Welfare 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-SM, please contact the Division of Social Services District Office or visit their website at dss.nv.gov. (Select *Applications & Forms* from the *Access NV* menu.)

Psychiatric Hospital, Inpatient

Rates

Inpatient psychiatric hospitals all-inclusive daily rates are negotiated by the provider through the Nevada Health Authority's (NVHA) Rate Analysis and Development Unit. Please see the Medicaid Services Manual (MSM) Chapter 700 and the Nevada Medicaid State Plan, Attachment 4.19-A, describing the methods and standards for reimbursement.

Since these are provider-specific cost-negotiated rates, providers can negotiate for higher rates via the Medicaid Rates Appeal process, discussed in detail in MSM Chapter 700, Section 704.

Appeals must be submitted in writing to the address below and clearly marked as a Rate Appeal. To ensure receipt of the appeal, certified mail or other commonly accepted delivery methods that clearly show the date of receipt are encouraged.

Appeal address: Rate Analysis & Development Unit, 4070 Silver Sage Drive, Carson City, NV 89701.

Claim submission instructions

Submit claims to Nevada Medicaid using Direct Data Entry (DDE) through the Provider Web Portal (PWP) or use an approved Trading Partner. See PWP User Manual Chapter 3 Claims and the EDI Companion Guides for claim submission instructions.

Special billing instructions

An Authorization Number issued by Nevada Medicaid must be entered on the claim.

Out-of-state inpatient providers with special rate reimbursement must be sure to bill (split bill, when applicable) only services that meet Nevada Medicaid coverage requirements and that are authorized, when authorization is required. The entire claim will be denied if services are billed on the claim that either do not meet coverage requirements or that occur on a date of service, requiring authorization, that was not authorized.

When a recipient is in a hospital for an extended period of time, providers must submit interim claims, as applicable, to avoid untimely/stale dated billing issues.

Each claim can only contain one authorization number.

Timely submission of a claim is calculated based on the "through" date on that claim. A claim filed untimely based on the "through" date on that claim will not be reimbursed.

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.

Psychiatric Hospital, Inpatient

- 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 and the PWP User Manual Chapter 3.