Rehabilitation, Specialty and Long Term Acute Care (LTAC) Hospital

Provider Type 56 Billing Guide

Policy

The Nevada Medicaid Services Manual (MSM) Chapter 200 contains State policy for Rehabilitation Specialty and Long Term Acute Care (LTAC) hospitals.

Contact Information

If you have any questions regarding prior authorization, please contact Magellan Medicaid Administration, Inc. at **(800) 525-2395**.

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

Resources

The Division of Health Care Financing and Policy (DHCFP) provides Nevada Medicaid and Nevada Check Up policy, rates, public notices and more via their website at http://dhcfp.nv.gov.

MSM Chapter 100 provides general information for all Nevada Medicaid providers, including information on:

- Pursuing third party liability prior to billing Medicaid (MSM Chapter 100, section 104)
- Billing Medicaid prior to the stale date (MSM Chapter 100, section 104.1)
- Interim billing for extended services (MSM Chapter 100, section 105.1A)

On http://nevada.fhsc.com, Magellan Medicaid Administration provides information on many subjects including provider training, billing, pharmacy, prior authorization (PA), and provider appeal rights related to claims, PA determinations and PA reconsiderations.

Prior Authorization

All Rehabilitation Specialty and LTAC hospital services require prior authorization except for services provided to Medicare and Medicaid dual eligible recipients when the services are covered by Medicare and Medicare benefits are not exhausted. Reference MSM Chapter 100, section 103.

Any service that is not prior authorized when needed will be denied for payment.

To request prior authorization from Magellan Medicaid Administration, use form FA-3 or log in to the Online Prior Authorization System (OPAS) to request prior authorization through the Internet.

Be sure that your prior authorization request includes clinical documentation to show that the recipient meets requirements specified in MSM Chapter 200.

If Magellan Medicaid Administration requests additional information to complete the prior authorization determination, the information must be submitted within one business day for eligible recipients or within five business days for retro eligible recipients.

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

An approved prior authorization does not guarantee claim 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

When a recipient is enrolled in a Managed Care Organization (MCO), request prior authorization from and submit claims to the MCO. For recipients in the Fee For Service plan, prior authorization is requested and payment is issued through Magellan Medicaid Administration.

Billing

Use a UB-04 claim form (for paper submissions) or an 837I transaction (for electronic submissions) to bill Rehabilitation Specialty and LTAC Specialty services.

Billed services must match the approved authorization.

Take Home Drugs

Take home drugs are billed through the Point-of-Sale (POS) system using the hospital's Pharmacy NPI. Do not include take home drugs on your UB-04/837I claim.

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

Rates

Covered days are paid at a provider specific per diem rate. General rate information is on the DHCFP website at http://dhcfp.nv.gov. (Select Rates from the main menu.)

Admit/Discharge/Death Notice

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