Critical Access Hospital (CAH), Inpatient

Program Overview

Critical Access Hospitals (CAHs) were established under the State Medicare Rural Hospital Flexibility Program as a result of legislation enacted as part of the Balanced Budget Act of 1997. CAHs represent a separate provider type with a different reimbursement methodology than general acute hospitals.

Medicaid provides reimbursement to CAHs for emergency, ICU/medical/surgical, maternity, newborn, skilled nursing or intermediate administrative days, emergency psychiatric and substance abuse treatment and acute medical detoxification services, as applicable. Swing bed placement, when prior authorized, is also reimbursed in facilities enrolled with Nevada Medicaid that have swing bed licensure and certification.

Providers who have difficulty placing an individual in a nursing facility may contact the Nevada Medicaid's Long Term Services and Supports Unit by calling (775) 684-3619.

Policy

For Nevada Medicaid covered services, service limitations and prior authorization requirements, refer to the Medicaid Services Manual (MSM) on the Nevada Medicaid website.

- See MSM Chapter 200 for Hospital Services

Managed Care Organization versus Fee-For-Service (FFS)

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 the Nevada Medicaid fiscal agent, Gainwell Technologies.

Rates

Provider-specific per diem rates have been established for each CAH provider. Provider-specific rates will not be shown in the Search Fee Schedule function on the Nevada Medicaid Provider Web Portal at medicaid.nv.gov.

Prior Authorization (PA)

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

Use the Authorization Criteria search function in the Provider Web Portal at medicaid.nv.gov to verify which services require authorization. Authorization Criteria is listed under "Featured Links" on the left side of every webpage.

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 form FA-3 or FA-8 as appropriate and submit through the Provider Web Portal (PWP).

Critical Access Hospital (CAH), Inpatient

Required Documentation:

Documentation for Authorization Requests:

- Give a synopsis of the medical necessity that you wish to have considered.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Documentation for Authorization Reconsideration:

- Give a synopsis of the medical necessity not presented in the initial authorization request that you wish to have considered.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Documentation for Retrospective Authorization:

- Give a synopsis of the medical necessity of all dates of service being requested.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Authorization requests must be received within the time frames listed below.

- **One business day** if the recipient was Medicaid-eligible on the date of service.
- **Ten 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 anticipated discharge date of the current/existing authorization period. For example, if the current authorization period is 05/11/18 through 05/15/18, then the concurrent authorization request is due by 05/16/18, which is the anticipated discharge date. If a concurrent authorization request is not received by the end date, a second authorization period, if clinically appropriate, can begin on the date Nevada Medicaid 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 Nevada Medicaid **requests additional clinical information** to complete an authorization request, the additional information must be submitted within five days of the request or a technical denial will be issued.

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

Emergent Transfers

The receiving hospital is responsible for obtaining admission authorization within one business day of admission.

Critical Access Hospital (CAH), Inpatient

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 or 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.

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.

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.
- Non-emergency admissions.
- Pre-planned change in level of care and/or transfer between hospital units.
- Hospital admissions for Induction of Labor (IOL) prior to thirty-nine (39) weeks gestation must be prior authorized as medically necessary to be eligible for reimbursement. Failure to obtain authorization for IOL prior to 39 weeks gestation will result in claim denial. Use Induction of Labor Prior to 39 Weeks form FA-8A.
- Hospital admission for Medicare Part A recipients after their Medicare benefits are exhausted. Reference Section 203.1.A in MSM Chapter 200.

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

- Emergency admissions or emergency transfers from one acute inpatient hospital to another (receiving facility's responsibility for transfers).
- Admissions initiated through emergency or observation when a physician writes the inpatient admission order.
- Obstetric or newborn admissions:

  1) that, from the date of admission, exceed two (2) calendar days for vaginal or four (4) calendar days for medically necessary or emergency cesarean delivery or 2) when delivery occurs immediately prior to hospital admission.

- See MSM Chapter 400, Section 403.10 for policy regarding alcohol and substance use disorder treatment and acute detoxification coverage and limitations, provider responsibilities, and authorization requirements. Admissions to a freestanding alcohol/substance use disorder hospital or specialty unit of a general hospital for acute detoxification must be authorized within one business day of admission. However, policy does not require that a recipient is first admitted for detoxification, prior to alcohol or substance use disorder treatment. A recipient can be admitted/transferred to these units/facilities for alcohol or substance use disorder treatment after prior authorization is obtained.

  Recipients can be admitted to an acute hospital without an alcohol/substance use disorder unit only for emergent, acute detoxification. Authorization must be obtained within one business day of admission. If additional treatment for alcohol/substance use disorder is required subsequent to acute detoxification, prior

authorization must be obtained and the recipient transferred to a specialty alcohol/substance use disorder unit in an acute hospital or a freestanding alcohol/substance use disorder facility.

Oral and Maxillofacial Surgery

Two prior authorizations are required: one for the procedure and a second for the admission. Providers must obtain authorization for the dental procedure before an authorization request for admission can be reviewed.

Peer-to-Peer Reviews and Reconsiderations

A Peer-to-Peer Review or Reconsideration can be requested for prior authorizations that are denied or modified. Please see the descriptions below to determine if a Peer-to-Peer Review or a Reconsideration is appropriate for your situation. If you request a Peer-to-Peer and afterward determine a Reconsideration is appropriate, the Reconsideration may be requested if within the timelines identified below. Once a Reconsideration is requested, you no longer have the option of requesting a Peer-to-Peer Review of the prior authorization.

Peer-to-Peer Review

A provider may request a Peer-to-Peer Review by emailing nvpeer_to_peer@gainwelltechnologies.com within 10 calendar days of the adverse determination. A Peer-to-Peer Review does not extend the 30-day deadline for Reconsideration.

Peer-to-Peer Reviews are a physician-to-physician discussion or in some cases between the Nevada Medicaid second level clinical review specialist and a licensed clinical professional operating within the scope of their practice. The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the Peer-to-Peer Review. New information is not accepted in a peer-to-peer review.

Reconsideration

Reconsideration is a written request from the provider asking Gainwell Technologies or Nevada Medicaid (as appropriate) to re-review a denied or reduced authorization request.

Reconsideration is not available for technical denials.

The provider must request Reconsideration within *30* calendar days from the date of the original determination.

For a Reconsideration request, the provider is also responsible to provide additional medical information (e.g., intensity of service, severity of illness, risk factors) that might not have been submitted with the original/initial request that supports the level of care/services requested.

Nevada Medicaid will notify the provider of the outcome of the Reconsideration within 30 calendar days. The 30-day provider deadline for Reconsideration is independent of the 10-day deadline for Peer-to-Peer Review.

If proper medical justification is not provided to Nevada Medicaid 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. Nevada Medicaid will not consider new information provided after the reconsideration is completed. Providers have three opportunities to request and address these issues with Nevada Medicaid: as part of the initial request, during a Peer-to-Peer review or during a Reconsideration.

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

Authorization submission time frames related to vaginal and C-section deliveries

- An obstetric admission: The request must be submitted by the second (2nd) inpatient day related to a vaginal delivery performed at or after 39 weeks gestation, or must be submitted by the fourth (4th) inpatient day related

to a medically necessary cesarean delivery.

- A newborn admission: The request must be submitted by the second (2nd) inpatient day related to a vaginal delivery or by the fourth (4th) inpatient day related to a medically necessary cesarean delivery, for admissions not involving Neonatal Intensive Care Unit days.

Hospital Presumptive Eligibility Authorization Process

For recipients who are not eligible upon admission but become eligible through the presumptive eligibility process, the authorization requests are processed as retrospective authorizations:

- Once the eligibility is showing in the PWP, the provider has 10 business days to submit the request to Nevada Medicaid.
- If the patient is still in-house, Nevada Medicaid reviews the request in the same time frame as any other initial or concurrent review (one day).
- If the patient has been discharged on or prior to the date of Nevada Medicaid's receipt of the retrospective authorization request, Nevada Medicaid has 30 calendar days to review the request.

Special Billing Instructions

See PWP Chapter 3 Claims and the EDI companion guides for billing instructions. An Authorization Number issued by Nevada Medicaid must be entered on the claim, as appropriate.

- 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, unless the claim contains services from multiple calendar months. In that case, the stale date for each individual service provided in a previous month is calculated from the last day of the month in which that service was provided. For example, if a claim with a "through" date of May 15 includes services rendered in March, April and May, the services rendered in March will have their stale date calculated from March 31; April services will use April 30; and May services will use May 15 (the "through" date). A claim line which is not submitted within the stale date as calculated by these rules 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:

Critical Access Hospital (CAH), Inpatient		

medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Critical Access Hospital (CAH), Inpatient

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 and the PWP User Manual Chapter 3.

Administrative Days

Use revenue codes 0160 and 0169 to bill for administrative days, as applicable. At least one acute inpatient day must immediately precede an administrative level of care day. Refer to MSM Chapter 200, Attachment A, Policy #02-03 for administrative day policy.

Admission from the community, another facility, a physician's office, an ER or observation directly to an administrative level of care are not covered.

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 Welfare District Office or visit their website at dss.nv.gov (select *Welfare Forms* from the Public Information menu). Refer to the Nevada Medicaid Services Manual, Chapter 200 for additional information.

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.

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

Critical Access Hospital (CAH), Inpatient

Family Planning Admissions

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

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, include both an ICD-10 procedure code and an ICD-10 diagnosis code on your claim.

Long Acting Reversible Contraception (LARC) may be provided during a CAH inpatient maternity stay, in addition to the maternity per diem. Claims must be billed separately by the associated PT 12 (Hospital, Outpatient) location on an outpatient claim for the insertion/removal procedure and payment will be based on the rendering provider type.

The insertion and removal of LARC devices are invoiced using the following codes:

- 58300 (Insertion of IUD)
- 58301 (Removal of IUD)
- 11981 (Insertion of a drug delivery implant)
- 11982 (Removal, non-biodegradable drug delivery implant)
- 11983 (Removal and reinsertion of a non-biodegradable drug delivery implant)

Procedure codes 58300, 58301, and 11982 have a service limit of 2 units allowed per day. Procedure codes 11981 and 11983 have a service limit of 2 units allowed per 3 rolling years.

LARC devices are billed separately using the following codes and claims for these codes must include the associated National Drug Code (NDC):

- J7296 (Kyleena, 19.5 MG – IUD)
- J7297 (Liletta, 52 MG – IUD)
- J7298 (Mirena, 52 MG – IUD)
- J7300 (Intrauterine Copper Contraceptive)
- J7301 (Skyla, 13.5 MG – IUD)
- J7307 (Etonogestrel Implant System)

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

For non-U.S. citizens eligible for emergency medical only coverage, 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:

- 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.

Critical Access Hospital (CAH), Inpatient

Reference "ICD-10-CM Emergency Diagnosis Codes for Non-U.S. Citizens with Emergency Medical Only Coverage" for a list of diagnosis codes for which emergency medical services are covered (at medicaid.nv.gov, select "Procedure and Diagnosis Reference Lists" from the "Prior Authorization" menu). This list also includes diagnoses related to the provision of outpatient emergency dialysis through the Federal Emergency Services Program.

Prior Authorization Submission and Billing Instructions for Newborn and/or Neonatal Intensive Care Unit (NICU)

- Nevada Medicaid will review NICU prior authorization requests per the table below effective with dates of service on or after January 1, 2015.
- Hospitals will submit prior authorization requests in the Provider Web Portal at the most appropriate InterQual Level and related National Uniform Billing (NUB) revenue code based on the table below.

NURSERY/NICU LEVEL OF CARE

Level of Care/InterQual*	UB Revenue Code	UB Level**
General LOC/Newborn Nursery	170/171	Level I
InterQual Level I/Transitional Care	172	Level II
InterQual Level II	173	Level III
InterQual Level III & IV	174	Level IV

* Level of Care/InterQual Level will be based on current published InterQual criteria/definitions. McKesson/InterQual® is the proprietary, nationally recognized standard utilized by Nevada Medicaid's QIO-like vendor to perform utilization management, determine medical necessity, and appropriate level of care. Many hospitals in Nevada also use this same selected tool for self-monitoring.

**Corresponds with National Uniform Billing Committee revenue code descriptions and guidelines.

Swing Beds (*Medicare Certified* in rural or critical access hospitals only)

Refer to the Billing Guide for provider type 44 (Swing-bed, Acute Hospital) for billing instructions. Refer to MSM Chapter 200, Attachment A, Policy #02-04 for Hospital with Swing Bed policy.

Sterilization Consent Form

If the Sterilization Consent Form is absent, the claim reimbursement will be cut back (the per diem rate) for the inpatient date that the sterilization was performed.

Take-Home Drugs

- Take-home drugs are billed through the Point-of-Sale (POS) system using the hospital's Pharmacy National Provider Identifier (NPI). Do not include take-home drugs on your claim.
- See MSM Chapter 1200 for Nevada Medicaid coverage and criteria for medications.

Critical Access Hospital (CAH), Inpatient

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 with a claim, when a copy of the form is not on file with Nevada Medicaid, will result in denial of the inpatient day that the sterilization was performed. For additional requirements, see the Sterilization and Abortion Policy, which is located on the Providers Billing Information webpage at medicaid.nv.gov/providers/BillingInfo.aspx.
- Out-of-state inpatient providers with special rate of reimbursement that bill for a tubal ligation without submitting a sterilization form meeting all federal sterilization consent form requirements with a claim, must only bill (split bill) for services provided on inpatient days during which the sterilization procedure was not performed. The entire claim will be denied if other services provided on the same date of service as the tubal ligation are billed and the required consent form is not submitted with the claim.