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. Swingbed placement, when prior authorized, is also reimbursed in facilities enrolled with DHCFP that have swing bed licensure and certification.

MCO vs. 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 HP Enterprise Services (HPES).

Non-covered services

Refer to MSM Chapter 200, section 203 regarding non-covered services. Examples include, but are not limited to:

- 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 prior authorization is not obtained. See 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 HPES; or,
- Use the Provider Web Portal to complete/submit required information online.

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.
- **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 by the end date, a second authorization period, if clinically appropriate, can begin on the date HPES 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 HPES **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, **HPES 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 HPES within five business days of the determination. This is called requesting **reconsideration**.

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

Emergent transfers

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

Non-emergent transfers

The provider who initiates a recipient's nonemergent 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.

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

- 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. Use Induction of Labor Prior to 39 Weeks and Scheduled Elective C-Sections form FA-8A.
- Hospital admissions for elective avoidable Cesarean sections must be prior authorized and will be reimbursed at the minimum federal requirement for a normal vaginal delivery. Use form FA-8A.

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.

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 HPES, the hospital provider, along with the attending physician, is encouraged to participate in a peer-to-peer review with HPES' 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 cannot be effectively rendered at a lower level of care.

If proper medical justification is not provided to HPES 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 HPES at any later date.

Special billing instructions

Refer to the UB Claim Form Instructions to complete your claim.

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

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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.

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:

- 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.

The Emergency Room Code List provides a list of emergency services that may be reimbursed for persons who are eligible for emergency services only (at http://medicaid.nv.gov, 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.

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 when a copy of the form is not on file with HPES at the time the hospital submits their claim. For additional requirements, see *Sterilization and Abortion Policy*.

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Family Planning Admissions

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

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

A facility with available swing beds must request swing bed placement (instead of skilled administrative days) when a recipient no longer meets acute inpatient level of care criteria, specifically requires skilled nursing facility placement, and nursing facility placement is not available despite documented, comprehensive discharge planning efforts. If there is no swing bed available or a hospital does not have swing beds, a facility can request authorization for administrative days.

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 and revenue code 0550 to bill for authorized swing bed days under provider type 44 (Swing-bed, Acute Hospital).

Bill ancillary fees for swing beds under provider type 12 (Hospital, Outpatient). Refer to MSM Chapter 500, Section 503.11 regarding ancillary services paid outside the swing bed daily rate.

Prescription drugs may be billed by either an independent service provider or the hospital's outpatient pharmacy through the Point of Sale system using the provider's pharmacy NPI and the applicable National Drug Code (NDC).

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.

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, section 203 regarding administrative day requirements.

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 http://dwss.nv.gov (select *Welfare Forms* from the Public Information menu).

Refer to the Nevada Medicaid Services Manual, Chapter 200 for additional information.

Rates

A per diem rate has been established for all providers. Rate information is posted on the web at http://dhcfp.nv.gov (select *Rates* from the DHCFP Index).