Rural Emergency Hospital (REH), Outpatient

Rural Emergency Hospital Policy

Rural Emergency Hospitals (REH) commonly provide outpatient services that do not exceed an annual per patient average length of stay of 24 hours including but not limited to:

- Emergency department services
- Observation care and
- Additional outpatient medical and health services if elected by the REH

REHs are prohibited from providing inpatient services, except those furnished in a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services. **REHs are required to have an active transfer agreement to a level I or level II trauma center.**

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/resources/medicaid-services-manual/.

Rural Emergency 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 limitations, and prior authorization requirements. This chapter contains important information applicable to *all* provider types.

For **reimbursement rates**, see the *Provider Type 96: Rural Emergency Hospital (REH), Outpatient Rates* document on the Rates page of the Nevada Medicaid website. Rates are also available on the Provider Web Portal at www.medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Provider Web Portal (PWP) Login webpage under Resources (you do not need to log in).

The Nevada Medicaid provider website, 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.

Prior Authorization (PA)

PA is not required for emergency services or observation.

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

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 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 into the Nevada Medicaid website, medicaid.nv.gov,

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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 services 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 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 and the PWP User Manual Chapter 3

Mental Health Services in the Emergency Room (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.

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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.

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.

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

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.

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. Refer to the Emergency Medicaid Only (EMO) Billing Instructions for further information about EMO services and coverage.

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.

End Stage Renal Disease Services (ESRD)

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). 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.

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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])

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.

Emergent Transfers to Level I/II Trauma Facilities

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

Non-emergent Transfers to Other Facilities

The provider who initiates a recipient's non-emergent transfer from a rural emergency 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.

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 Chapter 3 Claims for billing instructions.

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

Billing Instructions

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

Billed services must match the approved authorization.