Billing Guidelines for:

11 Hospital, Inpatient

A hospital is an inpatient medical facility that provides services at an acute level of care for the diagnosis, care and treatment of human illness, primarily for patients with disorders other than mental diseases.

For purposes of Medicaid policy, a hospital does not include Institutions for Mental Diseases (IMDs), Nursing Facilities (NFs), or Intermediate Care Facilities for the Mentally Retarded (ICF/MRs).

Covered Services

Medicaid covers medical/surgical, maternity, newborn, neonatal, rehabilitation, long-term acute, psychiatric and substance abuse services in an inpatient hospitals setting.

Please contact First Health Services' Customer Service Center at (877) 638-3472 or nevadamedicaid@fhsc.com if you have questions regarding coverage or requirements for a specific service or code.

Prior Authorization Requirements

To request prior authorization, use form FH-3 or FH-8 as appropriate or log in to the Online Prior Authorization System to request prior authorization via the Internet. Claims will be denied if prior authorization is not obtained when required, if a retrospective authorization request is denied, or if proper notice is not given when applicable.

The following services require prior authorization:

- Non-emergency admissions to in-state and out-of-state facilities.
- Admissions that are initiated through a same day surgery or observation status and due to medical necessity are requiring an admission to an acute inpatient status.
- Any surgery, treatment or invasive diagnostic testing that is not related to the reason for admission.
- Swing bed admissions. Refer to MSM Chapter 200 for requirements.
- Admissions resulting from a Healthy Kids screening.

- Transfers between any of the following units; 1) acute hospital bed, 2) psychiatric services, 3) alcohol/substance abuse services, 4) long term acute care, 5) rehabilitation units and 6) rollover from observation beds. This applies to both in state and out-of-state facilities.

The physician who transfers a recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, rehabilitation, specialty) is responsible for requesting prior authorization before the recipient is transferred.

- Oral and maxillofacial surgery. Two prior authorizations for a dental admission are necessary: one for the dental procedure and a second for the hospital admission.
- Family planning admissions. Refer to Sections 603.3 and 603.4 in MSM Chapter 600 for requirements.
- Hospital admission for Medicare Part A recipients after their Medicare benefits are exhausted. Refer to Section 203.1.A in MSM Chapter 200.
- Respite care for children in the physical and/or legal custody of the Division of Child and Family Services (DCFS) or in the Special Needs Adoption Program. Refer to Section 203.1.A in MSM Chapter 200.
- Newborn and/or Neonatal Intensive Care Unit (NICU) admissions (using Rev Code 173 & 174) require prior authorization using the newborn's Recipient ID Number. If the newborn has not been assigned a Recipient ID Number, you must submit a retroactive prior authorization request within 90 days after the newborn is assigned a Recipient ID Number.
- Antepartum admissions for delivery when an additional elective procedure is planned (excluding tubal ligations).
- Therapeutic passes from an acute hospital to the community that are expected to last longer than eight hours.

Notification Requirements

When providing the following services, you must notify First Health Services at (800) 525-2395 within 24 hours or the first working day after the admission, whichever occurs sooner:

- Emergency admissions transferred from a physician's office or an emergency room.
- OB, maternity, newborn and/or neonatal admissions using (revenue code 171 & 172) greater than 3 days for the purpose of vaginal delivery, and greater than 4 days for C-Sections (elective and emergency).
- Tubal ligations performed at the time of obstetric delivery. Be sure to submit a Sterilization Consent Form with your claim. For additional requirements, see "Sterilization and Abortion Policy."

Maternity Services

Submit two claims for maternity services: one for the newborn, and a second for the mother. On claims for services to newborns, use the newborn's 11-digit Recipient ID Number. (The newborn must have his/her own Recipient ID Number or you cannot bill for services rendered to him/her.)

When billing for maternity services that do not require prior authorization, include an ICD-9 code on your claim.

For NICU admissions, refer to the Prior Authorization Requirements section above.

Additional Notes

Please refer to the UB-92 Claim Form Instructions to complete your claim. See MSM Chapter 200 for additional policy and guidelines.

Revenue codes for administration days prior to March 1, 2004 are 0220 and 0229. Beginning on March 1, 2004, use revenue codes 0160 and 0169 to bill for administration days.