Hospital, Inpatient

Program Overview

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 Individuals with Intellectual Disabilities.

See Medicaid Services Manual (MSM) Chapter 200 for additional policy and guidelines.

Managed Care vs. 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 FFS plan, request prior authorization from and submit claims to HP Enterprise Services (HPES).

Rates

Rates information is on the DHCFP website at https://dhcfp.nv.gov (select "Rates" from the DHCFP Index at left).

Authorization

Claims will be denied if proper authorization is not obtained. See MSM 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.

Hospitals are not permitted to submit a claim as an outpatient service after an inpatient service has been authorized.

Requesting Authorization

To request authorization:

- Complete and fax form FA-3 or FA-8 as appropriate to HPES; or
- Use the online prior authorization system 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. These retro eligible notification requirements apply even if a recipient has TPL.
- **Concurrent authorization requests** must be received by the end date of the current/existing authorization period. If a concurrent authorization request is not received within this time frame, 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 business days of the 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.

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

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, except a change between medical/surgical and intensive care.
- 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 an elective Cesarean section or IOL prior to 39 weeks gestation will result in claim denial. 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 are reimbursed at the minimum federal requirement for a normal vaginal delivery. Use 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 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 3 calendar days for vaginal or 4 calendar days for medically necessary or emergency Cesarean delivery or
  2. when delivery occurs immediately prior to hospital admission. (See *Prior Authorization Requirements for Obstetrical Hospital Admissions* on last page.)

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.

Newborn and/or Neonatal Intensive Care Unit (NICU)

Newborn and/or Neonatal Intensive Care Unit (NICU) admissions using revenue codes 0170, 0171, 0172, 0173 and 0174

- An initial newborn admission using codes 0170, 0171 and 0172 do not need a prior authorization unless the inpatient days go beyond 3 days for a vaginal delivery or 4 days for a Cesarean delivery (MSM Chapter 200, Section 203.1A.2g.2).
- When a newborn goes directly to NICU (0173 and 0174), an authorization is required within one business day (MSM Chapter 200, Section 203.1A. 2g.5).
- When a newborn goes from newborn to NICU, authorization is required based on a change in level of care (MSM Chapter 200, Section 203.1A .2 f.10).
- If the newborn does not have a Recipient ID when admitted, but receives one during their stay, prior authorization must be requested **within five business days of the date of eligibility decision.**

- If the newborn receives a Recipient ID after discharge, a retroactive authorization request must be submitted **no later than 90 calendar days after the newborn is assigned a Recipient ID.**
- Prior authorization must be requested using the newborn's Recipient ID.

Prior Authorization Submission and Billing Instructions for NICU

- The Division of Health Care Financing and Policy (DHCFP) 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.

Family Planning Admissions

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

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.

Oral and Maxillofacial Surgery

Two prior authorizations are required: one for the procedure and a second for the admission.

Special Billing Instructions

Please 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.

Emergency Room (ER)

ER 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 per diem rate for the date of admission, even if the emergency services are provided on the calendar date preceding the admission date. Do not bill outpatient emergency services in addition to the inpatient per diem rate.

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 Diagnosis Codes for Non-Citizen Coverage Only document provides a list of pregnancy-related/obstetric emergency services that may be paid for persons who are eligible for emergency services only (at https://www.medicaid.nv.gov, select "Procedure and Diagnosis Reference Lists" from 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 up to the 48-hour policy limit.

Please refer to the Billing Guide for Provider Type 12, Hospital Outpatient.

Denied Inpatient Admissions

Physician-ordered medically necessary services provided prior to the inpatient admission denial must be billed as outpatient services.

Administrative Days

Use revenue codes 0160 and 0169 to bill for administrative days, as applicable. At least one acute inpatient hospital day must immediately precede an administrative level of care day.

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

For requirements on requesting concurrent authorization, please see the "Requesting Authorization" section beginning on page 2 in this document.

Refer to MSM Chapter 200, Attachment A, Policy #02-03 for Administrative Day policy.

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-9 procedure code and an ICD-9 diagnosis code** on your claim. Note: Use ICD-9 codes on claims with dates of service prior to October 1, 2015. **Use ICD-10 codes on claims with dates of service on or after October 1, 2015.**

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 and MSM Chapter 600, Attachment B, Sterilization Consent Form.

Psychiatric/Detoxification

Any acute inpatient days authorized at a psychiatric/detoxification level of care must be billed separately from days authorized at a medical/surgical/ICU level of care. Refer to MSM Chapter 400, Section 403.9 for additional information.

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 and Swing Bed policy.

Discharge Day

The date of discharge is not reimbursed, except when discharge/death occurs on the day of admission.

Leave of Absence

Providers must notify HPES and, when applicable, obtain prior authorization for a leave of absence that exceeds eight hours or involves an overnight stay. Bill the inpatient day(s) related to the leave of absence according to the authorized revenue code.

Admit/Discharge/Death Notice

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

Prior Authorization Requirements for Obstetrical Hospital Admissions

Medically Necessary Vaginal Delivery	Day Prior to Delivery	Day of Delivery	First Post Partum Day	Second Post Partum Day	Third Post Partum Day	Fourth Post Partum Day
Normal	n/a	Covered at maternity level. Prior authorization not required.			n/a	n/a
With complications that require a stay of more than 3 days	n/a	Request prior authorization for 3 maternity-level days and 1 acute med/surg level day.				n/a
Induced labor (at 39 weeks or more gestation) with or without complications that require a stay of more than 3 days	n/a	Request prior authorization for 3 maternity-level days and 1 acute med/surg level day.				n/a
With active labor that meets acute level of care criteria prior to the day of delivery	**Call HP Enterprise Services at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and 3 maternity-level days.				n/a	n/a
With active labor that meets acute level of care criteria prior to the day of delivery and medical complications after delivery that require a stay of more than 3 days	**Call HP Enterprise Services at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and up to 4 normal maternity days**. If additional days meet acute med/surg level of care criteria**, call HP Enterprise Services again to request that the additional days be added to the authorization.					n/a
Medically Necessary Cesarean Delivery	**Labor**	**Day of Delivery**	**First Post Partum Day**	**Second Post Partum Day**	**Third Post Partum Day**	**Fourth Post Partum Day**
Normal	n/a	Covered at maternity level. Prior authorization not required.				n/a
With complications that require a stay of more than 4 days	n/a	Request prior authorization for 4 maternity-level days and 1 acute med/surg level day.				
With complications during labor that met acute level of care criteria	**Call HP Enterprise Services at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and up to 4 normal maternity days.					n/a
With active labor that meets acute criteria prior to the day of delivery and medical complications after delivery that require a stay of more than 4 days	**Call HP Enterprise Services at (800) 525-2395 within one business day of labor** to request prior authorization for 1 active labor day and up to 4 normal maternity days. **If additional days meet acute med/surg level of care criteria**, call HP Enterprise Services again to request that the additional days be added to the authorization.					

Please note: These requirements do not apply to hospital admissions for elective or avoidable scheduled Cesarean sections or early induction of labor prior to 39 weeks gestation, which must be prior authorized. Refer to MSM Chapter 200, sections 203.1 A 1 g-h and 203.1 A 2 f 2-3 for coverage and policy requirements.