



## Inpatient Rehabilitation and Long Term Acute Care (LTAC) Specialty Hospitals

### Policy

The Nevada [Medicaid Services Manual \(MSM\)](#) Chapter 200 contains State policy for Inpatient Rehabilitation and Long Term Acute Care (LTAC) Specialty Hospitals.

### Contact information

If you have any questions regarding prior authorization, please contact Nevada Medicaid at **(800) 525-2395**. If you have questions that pertain to billing, please contact the Customer Service Center at **(877) 638-3472**.

### Resources

The Division of Health Care Financing and Policy (DHCFP) provides Nevada Medicaid and Nevada Check Up policy, rates, public notices and more via their website at <http://dhcfcv.nv.gov>.

[MSM Chapter 100](#) provides general information for all Nevada Medicaid providers, including information on:

- Pursuing third party liability prior to billing Medicaid (MSM Chapter 100, section 104)
- Billing Medicaid prior to the stale date (MSM Chapter 100, section 104.1)
- Interim billing for extended services (MSM Chapter 100, section 105.1A)

At [www.medicaid.nv.gov](http://www.medicaid.nv.gov), Nevada Medicaid provides information on many subjects including provider training, billing, pharmacy, prior authorization (PA), provider appeal rights related to claims, PA determinations and PA reconsiderations.

### Authorization

**All Inpatient Rehabilitation Specialty and LTAC hospital services require prior authorization except for services provided to Medicare and Medicaid dual eligible recipients when the services are covered by Medicare and Medicare benefits are not exhausted. Reference MSM Chapter 100, section 103.**

Claims will be denied if required authorization is not obtained.

To request prior authorization from Nevada Medicaid (Gainwell Technologies, which is referred to as Nevada Medicaid), log in to the Nevada Medicaid online prior authorization system and use form [FA-3 \(Inpatient Rehabilitation\)](#) or [FA-4 \(Long Term Acute Care\)](#).

Be sure that your prior authorization request includes clinical documentation to show that the recipient meets requirements specified in [MSM Chapter 200](#).

If Nevada Medicaid requests additional information to complete the prior authorization determination, the information must be submitted within *five business days* or the request will be denied for insufficient information (a technical denial).

**Prior authorization is valid for the dates of service shown on the authorization.** If a service cannot be provided within the authorized dates, the prior authorization becomes invalid and the provider must obtain another authorization that reflects the proper service dates.

- **An approved prior authorization does not guarantee claim 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.

### Authorization time frames

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



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- Initial admissions must be prior authorized before admission to this level of care.
- **Within 10 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.
- **Within 90 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 Third Party Liability (TPL).
- **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 05/11/15 through 05/15/15, then the concurrent authorization request is due by 05/16/15, which is the anticipated discharge date. If a concurrent authorization request is not received within this time frame, 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.

### ***Reconsideration and peer-to-peer review for acute inpatient admissions***

The provider is responsible for having a clinician who is knowledgeable about the case participate in the peer-to-peer review. New information will not be accepted.

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.

If proper medical justification is not provided to Nevada Medicaid, this demonstrates failure of the provider to comply with proper documentation requirements. New information will not be accepted at a hearing preparation meeting.

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

### ***Administrative Days***

Administrative days can be requested when a recipient no longer meets an acute level of care and, if discharge is ordered, placement in an alternate appropriate setting is not available despite a hospital's documented, comprehensive discharge planning efforts. Use revenue codes 0160 and 0169 to bill for administrative days, when applicable.

## **Managed Care vs. Fee-for-Service**

When a recipient is enrolled in a Managed Care Organization (MCO), request prior authorization from and submit claims to the MCO. For recipients in the Fee-for-Service plan, prior authorization is requested, and payment is issued through Nevada Medicaid (Gainwell Technologies).

## **Billing**

Use Direct Data Entry (DDE) via the Provider Web Portal or an 837I transaction to bill Inpatient Rehabilitation and LTAC Specialty Hospital services. See [Electronic Verification System \(EVS\) Chapter 3 Claims](#) on the [EVS User Manual](#) webpage or the 837I Companion Guide on the [Electronic Claims/EDI](#) webpage for billing instructions.

### ***Discharge Day***

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



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### 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.

### Rates

Covered days are paid at a provider specific per diem rate. General rate information is on the DHCfp website at <http://dhcfc.nv.gov>. (Select [Reimbursement, Analysis and Payment](#) from the "Resources" menu.)

### Admit/Discharge/Death Notice

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

### 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: <https://www.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 located at: <https://www.medicaid.nv.gov/providers/edi.aspx> and the Electronic Verification System (EVS) User Manual Chapter 3 located at: <https://www.medicaid.nv.gov/providers/evsusermanual.aspx>