Rehabilitation, Specialty and Long Term Acute Care (LTAC) Hospital

Policy

The Nevada Medicaid Services Manual (MSM) Chapter 200 contains State policy for Rehabilitation Specialty and Long Term Acute Care (LTAC) hospitals.

Contact information

If you have any questions regarding prior authorization, please contact HP Enterprise Services 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://dhcfp.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, section104)
- Billing Medicaid prior to the stale date (MSM Chapter 100, section 104.1)
- Interim billing for extended services (MSM Chapter 100, section 105.1A)

On http://medicaid.nv.gov, HP Enterprise Services provides information on many subjects including provider training, billing, pharmacy, prior authorization (PA), and provider appeal rights related to claims, PA determinations and PA reconsiderations.

Prior authorization

All 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 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 prior authorization

To request authorization:

- Complete and fax form FA-3 or FA-8 as appropriate to HP Enterprise Services; or,
- Use the Provider Web Portal to complete/submit required information online.

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Authorization requests must be received within the timeframes 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 HP Enterprise Services 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 HP Enterprise Services **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, **HP Enterprise services 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 HP Enterprise Services within five business days of the determination. This is called requesting '**reconsideration**.'

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

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 HP Enterprise Services.

Billing

Use a UB-04 claim form (for paper submissions) or an 837I transaction (for electronic submissions) to bill Rehabilitation Specialty and LTAC Specialty services.

Billed services must match the approved authorization.

Take Home Drugs

Take home drugs are billed through the Point-of-Sale (POS) system using the hospital's Pharmacy NPI. Do not include take home drugs on your UB-04/837I claim.

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

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Rates

Covered days are paid at a provider specific per diem rate. General rate information is on the DHCFP website at http://dhcfp.nv.gov. (Select Rates from the main 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.