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://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, 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, 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 (DXC Technology, which is referred to as Nevada Medicaid), log in to the Nevada Medicaid online prior authorization system or 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.

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- **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.

- Initial admissions must be prior authorized before admission to this level of care.
- **Ten 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 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.

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 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.

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.

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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 (DXC Technology).

Billing

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

Discharge Day

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

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 UB-04/837I 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://dhcfp.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.