July 10, 2019 *(Updated July 15, 2019)*

Web Announcement 1924

Attention Provider Type 13 (Psychiatric Hospital, Inpatient):

Nevada Medicaid Reimbursement per Institution for Mental Disease (IMD) Guidelines

Nevada Medicaid Fee-for-Service (FFS) cannot reimburse for services to individuals ages 22 to 64 (or 21 to 64, if the criteria are not met for 21-22 to be covered) due to the Institution for Mental Disease (IMD) guidelines that Federal Financial Participation (FFP) is not available for institutionalized individuals between these ages. Refer to Medicaid Services Manual (MSM) Chapter 400, Attachment D for further explanation.

Medicaid may reimburse co-pays and/or deductibles for Qualified Medicare Beneficiaries (QMBs) while in an IMD only, up to the Medicaid allowable amount for recipients between the age ranges specified above.

IMD as defined in 42 CFR 435.1010 means, "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such."

If the Explanation of Benefits (EOB) shows no amount due for a co-pay or deductible, then Medicaid will not reimburse either. Additionally, Chapter 200 of the MSM states, "QMB claims denied by Medicare are also denied by the DHCFP." Per MSM Chapter 100, Section 104.1, "Medicaid payment, even a zero-paid amount, is considered payment in full and no additional amount may be billed to the recipient, his or her authorized representative or any other source."

Please refer to policy in the MSM for more details regarding IMDs, QMBs and co-pays and deductibles.

Claims must also be submitted within the stale date period as outlined in policy and the Billing Manual. In-state providers must submit claims within 180 days; when a third-party resource exists and for out-of-state providers, claims must be submitted within 365 days. Requests for adjustments to paid claims, including zero-paid claims, must be received by Nevada Medicaid no later than the Medicaid stale date period. (Reference Chapter 100, Section 105.2C of the MSM.)

For additional information and resources, please also refer to:

- Web Announcement 1876: Training on locating valuable resources on the DHCFP and Medicaid websites, submitting prior authorizations and submitting claims electronically
- Web Announcement 1858: Upcoming Training Sessions Regarding Claims Appeals, Adjustments and Voids
- Reading a Remittance Advice (RA): Training presentation explains obtaining and understanding an RA via the Electronic Verification System (EVS)