Advance Directive means an advance directive is a written instruction, such as a living will or power of attorney for health care, recognized under State law (statutory or as recognized by the courts of the State) that relates to the provision of medical care if the individual becomes incapacitated.

Alternative Services means living arrangements providing less care than NF, ICF/MR, IMD, or inpatient psychiatric hospital, and more than independent living, such as adult family home, board and room, or assisted living.

Appropriate means that which best meets the client's needs in the least restrictive setting.

Bedholding means ~~full per diem~~ reimbursement made to a facility to hold a bed when a client is hospitalized and return is anticipated or on therapeutic leave.

Brain Injury means any level of injury to the brain often caused by an impact with the skull. Mild symptoms include persistent headaches, mood changes, dizziness, and memory difficulties. Severe head injury symptoms are more obvious: loss of consciousness; loss of physical coordination, speech, and many thinking skills; and significant changes in personality.

1. Acquired Brain Injury (ABI): An injury to the brain that has occurred after birth and which may result in mild, moderate, or severe impairments in cognition, speech-language communication, memory, attention and concentration, reasoning, abstract thinking, physical functions, psychosocial behavior, or information processing.
2. Traumatic Brain Injury (TBI): An injury to the brain caused by external physical force and which may produce a diminished or altered state of consciousness resulting in an impairment of cognitive abilities or physical functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychological maladjustment.

Further definition of Brain Injury for both TBI and ABI are clarified as acute or chronic.

1. Acute Brain Injury means the injury or insult occurred two years or less from the date of admission to the current extended brain injury rehabilitation program as described in 471 NAC 12-014.01B.
2. Chronic Brain Injury means an insult or injury that occurred more than two years before admission to the current extended brain injury rehabilitation program as described in 471 NAC 12-014.01B.

Categorical Determinations means advance group determinations under PASP that take into account that certain situations, diagnoses, or levels of severity of illness clearly indicate that admission to or residence in a nursing facility is needed, exempting the client from a Level II evaluation for a specified period of time. These determinations must be based on current documentation, such as hospital/physician report, etc. (See 471 NAC 12-004.07.)

Central Office means the Medicaid Division in the Nebraska Department of Health and Human Services ~~Finance and Support~~ and other staff in Health and Human Services to whom administration of the Medicaid program has been delegated.
Certified Facility means a facility which participates in the Medicaid program, whether that entity comprises all or a distinct part of a larger institution.

CMS means centers for Medicare and Medicaid Services (the federal agency previously known as HCFA).

12-009.06C Other: The facility must meet the following requirements:

1. The facility must not charge a client (or his/her representative) for any item or service not requested by the resident.
2. The facility must not require a resident (or his/her representative) to request any item or service as a condition of admission or continued stay.
3. The facility must inform the client (or his/her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

12-009.07 Payment for Bedholding: The Department makes payments to reserve a bed in a NF during a client's absence due to hospitalization for an acute condition and for therapeutically-indicated home visits. Therapeutically-indicated home visits are overnight visits with relatives and friends or visits to participate in therapeutic or rehabilitative programs. Payment for bedholding is subject to the following conditions:

1. A "held" bed must be vacant and counted in the census. The census must not exceed licensed capacity;
2. Hospital bedholding is limited to ~~full per diem~~ reimbursement for 15 days per hospitalization. Hospital bedholding does not apply if the transfer is to the following: NF, hospital NF, swing-bed, a Medicare-covered SNF stay, or to hospitalization following a Medicare-covered (SNF) stay;
3. Therapeutic leave bedholding is limited to ~~full per diem~~ reimbursement for 18 days per calendar year. Bedholding days are prorated when a client is a resident for a partial year;
4. A transfer from one facility to another does not begin a new 18-day period;
5. The client's comprehensive care plan must provide for therapeutic leave; ~~and~~
6. Facility staff must work with the client, the client's family, and/or guardian to plan the use of the allowed 18 days of therapeutic leave for the calendar year; and
7. Qualifying hospital and therapeutic leave days will be reimbursed at the facility's bedhold rate (Level of Care 105), as identified in 471 NAC 12-011.08F.

12-009.07A Special Limits: When the limitation for therapeutic leave interferes with an approved therapeutic or rehabilitation program, the facility may submit a request for special limits of up to an additional six days per calendar year to the Medicaid Division. Requests for special limits must include:

1. The number of leave days requested;
2. The need for additional therapeutic bedholding days;
3. The physician's orders;
4. The comprehensive plan of care; and
5. The discharge potential.

It is mandatory that the NF report all ~~bed-holding~~ bedholding days on the monthly Form MC-4, "Long Term Care Facility Turnaround Billing Document" (see 471-000-82), UB04 claim form (see 471-000-71), or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837).

12-009.07B Use of Form MC-10: When a client, who was receiving Medicaid-covered NF services, returns from a hospital stay and is admitted for Medicare-covered services, a Form MC-10 is used to inactivate the authorization for Medicaid payment, effective the date on which the client is admitted to the Medicare-covered bed. The local office shall complete and submit another Form MC-10 to re-activate authorization for Medicaid payment when Medicare services are denied.

If the client is discharged from the hospital to swing bed care or to another nursing facility, the local office shall complete and submit Form MC-10 to deactivate Medicaid prior authorization. Note: The Department encourages the facility to communicate frequently with the hospital discharge planner to keep aware of the client's medical status.

12-009.07C Reporting Bedholding Days: Facilities shall report bedholding days on Printout MC-4, "Long Term Care Facility Turnaround Billing Document," (see 471-000-82). The appropriate bedholding days are reported in the "leave days therapeutic" or "leave days hospital" columns. If billing electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837), the appropriate bedholding days are reported in accordance with billing instructions (see 471-000-82). If billing on the UB04 claim form the appropriate bedholding days are reported in accordance with the billing instructions (see 471-000-71). The nursing home days are adjusted to the actual number of days the client was present in the facility at 12:00 midnight.

12-009.08 Swing Beds: Medicaid ~~NMAP~~ covers only skilled nursing care (client requires 24-hour professional nursing care) for swing beds. Also see 471 NAC 10-014 ff. Swing bed services are services that meet the requirements of 42 CFR 483, Subpart B. Nursing or rehabilitation services which must be provided by or under the direct supervision of professional or technical personnel and require skilled knowledge, judgment, observation, and assessment may include, but are not limited to, the following:

1. Orally administered medications which require changes in dosage due to undesirable side effects or reactions, e.g., anticoagulants, Quinidine, etc. These must be administered to the patient by licensed nurses;
2. Frequent intravenous or intramuscular injections, except self-administered types such as insulin for a well-regulated diabetic;
3. Narcotics and controlled substances used on a p.r.n. (as circumstances may require) basis. Care relative to these substances must be documented in nurses' notes and physicians' orders with progress notes which contain observations made of the physical findings, new developments in the disease cause, how the prescribed treatment was implemented, and the resultant effects of the treatment;
4. Supplementation of physician care when -
a. Uncontrolled or unstable medical conditions exist; and/or
b. Observations of and instructions to the patient are needed relative to critical complications and evaluation of progress;
5. Initial phases of a medical regimen involving the administration of medical gases as directed by physicians' orders;
6. Physician-ordered restorative procedures which, because of the type of procedure or the patient's condition, must be performed by or under the direct supervision of the appropriately qualified therapist as defined in 42 CFR 483.45 (Note: Maintenance therapy is not skilled nursing care);
7. Colostomy or ileostomy care during the post-operative period until routine care is established.

12-011 Rates for Nursing Facility Services

12-011.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost means those facility costs which are included in the computation of the facility's per diem. The facility's reported costs may be reduced because they are not allowable under Medicaid or Medicare regulation, or because they are limited under 471 NAC 12-011.06.

Assisted Living Rates means standard rates, single occupancy, rural or urban, per day equivalent, paid under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Department means the Nebraska Department of Health and Human Services.

Division means the Division of Medicaid and Long-Term Care.

IHS Nursing Facility Provider means an Indian Health Services Nursing Facility or a Tribal Nursing Facility designated as an IHS provider and funded by the Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

Level of Care means the classification of each resident based on his/her acuity level.

Median means a value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

Nursing Facility means an institution (or a distinct part of an institution) which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

Rate Determination means per diem rates calculated under provisions of 471 NAC 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 101, 102, 103 and 104.

Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 101, 102, 103 ~~and~~ , 104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

12-011.08D4 Inflation Factor: For the Rate Period of July 1, 2010 through June 30, 2011, the inflation factor is negative 1.54%. ~~F~~for future rate periods, the inflation factor will be calculated using the following formula and will not be specified in the regulations. Once calculated, rates are available for review from the Department.

1. Audited cost and census data following the initial desk audits; and
2. Budget directives from the Nebraska legislature.

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increase(s).

12-011.08F Rate Payment for Levels of Care 101, 102, 103 ~~and~~, 104 and 105: Rates as determined for Levels of Care 101, 102, 103 and 104 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. Level of Care 105 is used for payment of qualifying bedhold days. The payment rate for Levels of Care 101, 102, 103 ~~and,~~ 104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid ~~NMAP~~ at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

4. An incentive factor calculated at eight per cent of allowable costs is added to the allowable costs of proprietary facilities. An incentive factor calculated at four percent of allowable costs is added to the allowable costs of other than propriety facilities;
5. After a rate is agreed upon, the Department and the provider must enter into a contract. The contract, written by the Department, must include:
    a. The rate and its applicable dates;
    b. A description of the criteria for care;
    c. A full description of the services to be provided under the established per diem as well as any services that are not provided under the per diem and are billed separately; and
    d. Other applicable requirements that are necessary to be included in all Department contracts.
6. In lieu of the rate establishment procedure described in this section and under mutual agreement of both the provider and the Department, a multi-year contractual arrangement may be entered into by the parties. Reimbursement must reflect the facility's actual reasonable cost of providing services to special needs clients and must be updated annually using an appropriate inflation adjustment.

12-014.05B Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid ~~NMAP~~ at a rate established by that state's Medicaid program at the time of the establishment of the Nebraska Medicaid provider agreement. The payment is not subject to any type of adjustment.

12-014.05C Payment for Bedhold ~~Bed-Hold~~: The Level 105 rate, as defined in 471 NAC 12-011.08F, will be used as a basis for payment of ~~Payment for bed-hold for~~ hospitalization and/or therapeutic leave ~~is as defined in 471 NAC 12-009.07.~~ from which a prospective rate is negotiated.

12-014.06: The requirements of 471 NAC 12 apply to services provided under 471 NAC 12-014 unless otherwise specified in 471 NAC 12-014.

12-014.07 In-Home Services for Certain Disabled Children: This section applies to children age 18 or younger with severe disabilities living in their parents' home, also referred to as the "Katie Beckett" program (also see 469 NAC 2-010.01F).

Services for special needs children are a skilled level of care provided by a certified Home Health agency, licensed RN's or LPN's. These providers must have necessary training/experience in the care of ventilator-dependant, pulmonary, and/or other special needs clients.