10-004.05C Definition of Clinical Trials: For services not subject to FDA approval, the following definitions apply:

Phase I: Initial introduction of an investigational service into humans

Phase II: Controlled clinical studies conducted to evaluate the effectiveness of the service for a particular indication or medical condition of the patient; these studies are also designed to determine the short-term side effects and risks associated with the new service

Phase III: Clinical studies to further evaluate the effectiveness and safety of a service that is needed to evaluate the overall risk/benefit and to provide an adequate basis for determining patient selection criteria for the service as the recommended standard of care. These studies usually compare the new service to the current recommended standard of care.

10-004.06 Autopsies: Autopsies are a non-covered service under Medicaid.

10-004.07 Custodial or Respite Care: Medicaid does not cover hospital services that are custodial or respite care.

10-004.08 Facility Based Physician Clinics: Physician Clinic services provided in a hospital location or a facility under the hospital's licensure are considered content of the physician service, not outpatient hospital services. Physician clinic services are defined as the professional activity, any drugs and supplies used during that professional encounter and any other billable service provided in the physician clinic area.

1. Nebraska Medicaid does not recognize facility/hospital based non-emergency physician clinics for billing, reimbursement or cost reporting purposes except for itinerant physicians as defined in 471 NAC 18-004.41/10-005.21.
2. Services and supplies incident to a physician's professional service provided during a specific encounter are covered and reimbursed as physician clinic services if the service or supply is:
   a. Of the type commonly furnished in a physician's office;
   b. Furnished as an incidental, although integral, part of the physician professional services; and
   c. Furnished under the direct personal supervision of the physician.
3. The Physician's clinic services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-004.09 Tobacco Cessation Services: Tobacco cessation services are not covered as a hospital service. Please see 471 NAC 16-000, Pharmacy Services and 471 NAC 18-000, Physicians' Services for coverage information.

10-004.10 Hospital Acquired Conditions: Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that Medicaid will, at a minimum, identify as an HAC, those ~~secondary diagnosis~~ diagnoses codes that have been identified as Medicare HACs when not present on hospital admission.

10-004.11 Health Care Acquired Conditions: A health care-acquired condition (HCAC) means a condition occurring in any inpatient hospital setting, identified as a hospital acquired condition (HAC) by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients.

Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in 471 NAC 10-010.03B5 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital licensed as a Critical Access Hospital by the Department of Health and Human Services under 175 NAC 9 and certified for participation by Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, birth weight, procedure coding, comorbidity, and complications.

Direct Medical Education Cost Payment: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.

Disproportionate Share Hospital (DSH): A hospital located in Nebraska is deemed to be a disproportionate share hospital by having -

1. A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
2. A low-income utilization rate of 25 percent or more.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

DRG Weight: A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each stable DRG.

Health Care-Acquired Conditions: A health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a hospital acquired condition (HAC) by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Hospital Acquired Condition: A condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission.

Hospital Mergers: Hospitals that have combined into a single corporate entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

Hospital-Specific Base Year Operating Cost: Hospital specific operating allowable cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.
   Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Other Provider Preventable Conditions (OPPC): A wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group except Peer Group 5 and Peer Group 6.

Present on Admission (POA) Indicator: A status code the hospital uses on an inpatient claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs.

Provider Preventable Conditions (PPC): An umbrella term which is defined as two distinct categories. Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

10-011 Billing Requirements: Providers of hospital services shall submit claims to the Department on Form CMS-1450 see 471-000-51. Also see 471 NAC 3-003, Medicare/Medicaid Claims. Instructions for completing Form CMS-1450 have been published in the Nebraska Uniform Billing Data Element Specifications manual published by the Nebraska Uniform Billing Committee. Providers may purchase copies from the Nebraska Association of Hospitals and Health Systems. Providers using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) shall refer to the Claim Submission Table at 471-000-49.

10-011.01 Medicare Coverage: For a Medicare/Medicaid client, the provider shall bill Medicare for appropriate benefits before submitting a claim to Medicaid. (Exception: Medicare non-covered services covered by ~~NMAP~~ Medicaid).

10-011.02 Medicare Part B: If the Medicare/Medicaid client has exhausted his/her Medicare Part A benefits, the hospital shall bill these services or items to Medicare Part B if the client is covered by Part B before billing the Department. The hospital shall enter the amount approved by Medicare as a "prior payment" on Form CMS-1450 see 471-000-51 on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

10-011.03 Documentation: The Department requires that documentation when required, be submitted with each claim for hospital services. Documentation must be complete and legible.

Note: All Nebraska Medicaid Program clients sign a release of information statement when they apply for Medicaid. If the hospital requires another release, the hospital must obtain that release, based on the provider agreement with the Department.

10-011.04 Hospital Acquired Conditions (HAC): Effective for inpatient and inpatient crossover claims with a 'From' date of service on or after the effective date of this regulation, hospitals are required to report whether each diagnosis on a Medicaid claim was present at the time of patient admission, or present on admission (POA). Claims submitted without the required POA indicators will be denied. ~~Hospitals exempt from this requirement include critical access hospitals, cancer hospitals, children's hospitals and those hospitals exempted by Medicare.~~

For claims containing ~~secondary~~ diagnoses that are identified by Medicare as Hospital-Acquired Conditions, other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients ~~included in the list of HACs in Appendix 471-000-542~~ and for which the condition was not POA, ~~HAC secondary~~ these diagnoses will not be used for AP-DRG grouping. The claim will be paid as though any ~~secondary~~ diagnoses included in the list of HACs ~~in Appendix 471-000-542~~ were not present on the claim. The Department does not make additional payments for services on inpatient hospital claims that are attributable to HACs and are coded with POA indicator codes "N" or "U". Specifically, for hospitals paid under the:

1. Diagnostic related group (DRG) payment method, the Department does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).

2. Cost to Charges (CCR) payment method, the Department does not pay for charges attributable to the HAC.

3. Per Diem payment method, the Department will limit provider payment reductions to the extent that the identified PPC would otherwise result in an increase in payment, or if Medicaid can reasonably isolate for nonpayment the portion of the payment directly related to the PPC.

~~3~~4. The Department denies payment for any HAC that results in death or serious disability.

~~For complete billing instructions for POA and HAC, see Title 471 NAC Appendix 471-000-542.~~

10-011.04A Other Provider Preventable Condition (OPPC): Effective for inpatient, inpatient crossover, outpatient and outpatient hospital claims with a 'From' date of service on or after the effective date of this regulation, payment will be denied for the following Other Provider Preventable Conditions:

1. Wrong surgical or other invasive procedure performed on a patient;
2. Wrong surgical or other invasive procedure performed on the wrong body part;
3. Wrong surgical or other invasive procedure performed on the wrong patient.

10-012 Hospital Utilization Review (UR): Each hospital must have in effect a utilization review plan that provides for review of services provided by the hospital and by members of the medical staff to Medicaid patients.

10-012.01 Composition of the Utilization Review Committee: A UR committee consisting of two or more practitioners must carry out the UR function. At least two members of the committee must be doctors of medicine or osteopathy. The other members may be -

1. A doctor of medicine or osteopathy;
2. A doctor of dental surgery or dental medicine;
3. A doctor of podiatric medicine;
4. A doctor of optometry; or
5. A chiropractor.

10-012.01A UR Committee: The UR committee must be -

1. A staff committee of the institution; or
2. A group outside the institution established by the local medical society and some or all of the hospitals in the locality or established in a manner approved by CMS.