

10-003.05F5b Clinical Lab Services: Clinical laboratory services provided to hospital inpatients, outpatients, and non-patients are routinely performed by non-physicians (i.e., medical technologists or laboratory technicians) manually or using automated laboratory equipment. These clinical laboratory services do not require performance by a physician and are considered a technical component; there is no professional component for these services. The technical component must be billed as described in 471 NAC 10-003.05F1. Payment is made to the hospital as follows:

1. Inpatient Services: Payment is included in the hospital's payment for inpatient services. The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate;
2. Outpatient Services: Payment is made at ~~97.5 percent of~~ the fee schedule determined by CMS (see 471-000-520);
Note: Outpatient clinical laboratory services must be itemized on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure codes (see 471 NAC 10-010.06).
3. Non-Patient Services: Payment is made at ~~97.5 percent of~~ the fee schedule determined by CMS. (See 471-000-520)

10-003.05F5b1 Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.03B1b, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

There is no separate payment made to the pathologist for routine clinical lab services. To be paid, the pathologist must negotiate with the hospital to arrange a salary/compensation agreement.

10-003.05F5c Leased Departments: Leased department status has no bearing on billing or payment for clinical lab services. The hospital shall claim all clinical lab services, whether performed in a leased or non-leased department. Payment for the total service (professional and technical component) is made to the hospital. The Department does not make separate payment for the professional component for clinical lab services.

10-003.05F5d Anatomical Pathology Services: Anatomical pathology services are services which ordinarily require a physician's interpretation. If these services are provided to hospital inpatients or outpatients, the professional and technical components must be separately identified for billing and payment.

10-010 Payment for Hospital Services

10-010.01 (Reserved)

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for the Nebraska Medical Assistance Program excluding Nebraska Medicaid Managed Care Program's ~~(NMMCP)~~ capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. Specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. Provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. Takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective using methods established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

Each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio.

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

Allowable Costs: Those costs as provided in the Medicare statutes and regulations for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance cost.

Base Year: The period covered by the most recent ~~final~~ settled Medicare cost report, which will be used for purposes of calculating prospective rates.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

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.

Hospital-Specific Cost-to-Charge Ratio: Hospital-Specific Cost-to-Charge Ratio is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-Specific Cost-to-Charge Ratios used for outlier cost payments, ~~Low Volume/Unstable DRG CCR payments~~ and Transplant DRG CCR payments are derived from the outlier CCRs in the Medicare inpatient prospective payment system.

Indirect Medical Education Cost Payment: Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education payments.

Low-Income Utilization Rate: For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum (expressed as a percentage) of the fractions, calculated from acceptable data submitted by the hospital as follows:

1. Total Medicaid inpatient revenues (excluding payments for disproportionate share hospitals) paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals) in the same cost reporting period; and
2. The total amount of the hospital's charges for hospital inpatient services attributable to uncompensated care in ending in the calendar year preceding the Medicaid rate period, less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to uncompensated care does not include contractual allowances and discounts (other than for uncompensated care for patients not eligible for Medicaid), that is, reductions in charges given to other third-party payors, such as HMO's, Medicare, or Blue Cross.

~~Low Volume DRG: DRGs with less than 10 claims in the two year claims dataset used to calculate DRG relative weights.~~

Medicaid Allowable Inpatient Charges: Total claim submitted charges less claim non-allowable amount.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.

Reporting Period: Same reporting period as that used for its Medicare cost report.

~~Stable DRG: DRGs with at least 10 claims and a sufficient numbers of claims to pass the stability test in the two year claims dataset used to calculate DRG relative weights, excluding psychiatric, rehabilitation and transplant DRGs.~~

Severity Level: The extent of physiologic decompensation or organ system loss of function.

Tax-Related Costs: Any real or personal property tax, sales tax, excise tax, tax enacted pursuant to the Medicaid Voluntary Contribution Provider Specific Tax Amendment of 1991 (P.L. 102-234) or any amendments thereto, franchise fee, license fee, or hospital specific tax, fee or assessment imposed by the local, state or federal government, but not including income taxes.

Uncompensated Care: Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

~~Unstable DRG: DRGs without sufficient numbers of claims to pass the stability test in the two year claims dataset used to calculate DRG relative weights.~~

10-010.03B Payment for Peer Groups 1, 2, and 3 (Metro Acute, Other Urban Acute, and Rural Acute): Payments for acute care services are made on a prospective per discharge basis, except hospitals certified as a Critical Access Hospital.

For inpatient services ~~that are classified into a stable DRG~~, the total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
 - a. Direct Medical Education Cost Payment;
 - b. Indirect Medical Education Cost Payment; and
 - c. A Cost Outlier Payment.

For inpatient services that are classified into a ~~low volume or unstable DRG or a~~ transplant DRG, the total per discharge payment is the sum of -

1. The Cost-to-Charge Ratio (CCR) Payment amount; and
2. When applicable - Direct Medical Education Cost Payment.

10-010.03B1 Determination of Operating Cost Payment Amount: The hospital DRG operating cost payment amount for discharges that are classified into a **stable** DRG is calculated by multiplying the peer group base payment amount by the **Nebraska-specific** DRG relative weight.

10-010.03B1a Calculation of the APR-DRG Weights: For dates of service on and after July 1, 2014, the Department will use the All-Patient Refined Diagnosis Related Groups (APR-DRG) national relative weights to determine DRG classifications. The national weights are based on 3M's version 30 APR-DRG standard national weights.

~~10-010.03B1a Calculation of Nebraska-Specific DRG Relative Weights: For dates of admission on and after October 1, 2009, the Department will use the AP-DRG Grouper to determine DRG classifications. DRG relative weights are based on the average cost per discharge of each stable DRG, using Nebraska Medicaid inpatient fee-for-service paid claims data from the two most recently available and fully adjudicated state fiscal years. For DRG relative weights effective October 1, 2009, the Department will use SFY 2006 and SFY 2007 claims data.~~

~~The Department will include claims from all Peer Group 1, 2 and 3 in-state hospitals and claims from out-of-state hospitals with at least \$500,000 in payments and 50 claims in the two year claims dataset used for the relative weight calculation.~~

- ~~1. Nebraska Medicaid inpatient fee-for-service paid claim costs are calculated as follows:
 - ~~a. Extract the most recently available hospital Medicare cost report data with reporting periods that overlap the claims data used in the relative weight calculation. For DRG relative weights effective October 1, 2009, extract FYE 2007 Medicare cost report data.~~
 - ~~b. Calculate hospital-specific cost-to-charge ratios (CCRs) for each standard Medicare ancillary cost center, excluding direct medical education costs.~~
 - ~~c. Calculate hospital-specific cost per diems for each standard Medicare routine cost center, excluding direct medical education costs.~~
 - ~~d. Estimate the cost of each claim, excluding direct medical education costs. The ancillary portion of the claim cost is calculated by multiplying the Medicaid allowed charges at the revenue code level by the corresponding ancillary cost center CCR. The routine portion of the claim cost is be calculated by multiplying the Medicaid allowed days at the revenue code level by the corresponding routine cost center cost per diem.~~
 - ~~e. Inflate the ancillary portion of the claim costs based on the change in price index levels from the midpoint of the claims data service month to the midpoint of the rate year.~~
 - ~~f. Inflate the routine portion of the claim costs based on the change in price index levels from the midpoint of the Medicare cost reporting period to the midpoint of the rate year.~~
 - ~~g. Calculate inflation using CMS hospital price index levels published by Global Insight Inc.~~~~

~~2. Nebraska-specific relative weights are calculated as follows:~~

- ~~a. Remove from the claims data all psychiatric, rehabilitation, transplant, Medicaid Capitated Plans, and Critical Access Hospital discharges;~~
- ~~b. Remove Transfer claims with days less than the DRG average length of stay;~~
- ~~c. Remove statistical outlier claims with estimated costs three times the DRG standard deviation above or below the DRG mean cost per discharge for each DRG;~~
- ~~d. Remove claims with low volume DRGs with less than ten claims;~~
- ~~e. Of the remaining claims, conduct a stability test to using a statistical sample size calculation formula to determine the minimum number of claims within each DRG classification needed to calculate stable relative weights. Calculate the required size of a sample population of values necessary to estimate a mean cost value with 90 percent confidence and within an acceptable error of plus or minus 20 percent given the populations estimated standard deviation.~~
- ~~f. Remove claims with unstable DRGs without sufficient numbers of claims to pass the stability test~~
- ~~g. Of the remaining claims, determine the arithmetic mean Medicaid cost per discharge for each DRG by dividing the sum of all Medicaid cost for each DRG by the number of discharges;~~
- ~~h. Of the remaining claims, determine the statewide arithmetic mean Medicaid cost per discharge by dividing the sum of all costs for all discharges in the State by the number of discharges;~~
- ~~i. For each remaining, or stable DRG, divide the DRG arithmetic mean Medicaid cost per discharge by the statewide arithmetic mean Medicaid cost per discharge to determine the DRG relative weight;~~

10-010.03B1b Calculation of the Starting Point for the Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges with a **stable** DRG. For purpose of rate setting, the starting point shall be the Medicaid Peer Group Base Payment Amount effective on July 1 of state fiscal year (SFY) 2010.

SFY 2010 Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B1b in effect July 1, 2010. For the purpose of maintaining budget neutrality with the APR-DRG grouper system, the state fiscal year (SFY) 2011 Peer Group Base Rates will be increased by 61.05 percent.

10-010.03B1b(1) ~~Application of~~ Adjustment Based on Legislative Appropriations: The starting point for the peer group base payment amounts, as determined in section 10-010.03B1b, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The Peer Group Base Payment Amounts are adjusted annually and shall be effective each July 1.

10-010.03B2 Calculation of ~~Stable~~ DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a ~~stable~~ DRG meeting or exceeding Medicaid criteria for cost outliers for each ~~stable~~ DRG classification. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus ~~\$53,000.~~ \$30,000 for all neonate and nervous system APR-DRGs at severity level 3 and severity level 4.

For all other APR-DRGs, the outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus \$51,800. Cost of the discharge is calculated by multiplying the Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is 80 percent of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85 percent.

10-010.03B2a Hospital Specific Medicare Outlier CCRs: The Department will extract from the CMS PPS Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier CCRs effective October 1 of the year preceding the start of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs effective in the Medicare system on October 1, 2008.

10-010.03B2b Outlier CCRs Updates: On July 1 of each year, the Department will update the outlier CCRs based on the Medicare outlier CCRs effective October 1 of the previous year.

10-010.03B3 Calculation of ~~Stable DRG~~ Medical Education Costs:

10-010.03B3a Calculation of ~~Stable DRG~~ Direct Medical Education Cost Payments:

~~For discharges with stable DRGs,~~ Direct Medical Education (DME) payments are based on Nebraska hospital-specific DME payment rates effective during SFY 2010.

SFY 2010 Nebraska hospital-specific DME payment rates are described in 471 NAC 10-010.03B in effect July 1, 2010. Each SFY Nebraska hospital-specific DME payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The DME payment rates are adjusted annually and shall be effective each July 1.

On July 1st of each year, the Department will update DME payment rates by replacing each hospital's intern and resident FTEs with each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1 of the previous year.

10-010.03B3b Calculation of ~~Stable DRG~~ Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from the Department, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the operating cost payment amount.

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program. For rates effective October 1, 2009, the Department will determine the operating IME factors effective for the Medicare system on October 1, 2008 using the following formula:

$$[1 + (\text{Number of Interns and Residents} / \text{Available Beds})]^{0.405} - 1 * 1.35$$

On July 1 of each year, the Department will adopt the Medicare inpatient prospective payment system operating IME factor formulas and rate components in effect on October 1 of the previous year.

10-010.03B3c Calculation of Managed Care Organization (MCO) Medical Education Payments: The Department will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by ~~NMMCP~~ capitated plans from discharge data provided by the plans.

1. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the MCO direct medical education payment per discharge. The MCO direct medical education payment per discharge is the hospital specific fee-for-service DME payment rates for ~~stable DRGs, unstable or low volume DRGs and transplant DRGs~~ **stable DRGs.**
2. ~~MCO Indirect Medical Education payments will be equal to the fee-for-service IME operating factor multiplied by the MCO operating payments. MCO Indirect Medical Education payments will be equal to the number of MCO discharges times the MCO indirect medical education payment per discharge. The indirect medical education payment per discharge is calculated as follows:~~
 - a. ~~Subtotal each teaching hospital's fee-for-service inpatient acute indirect medical education payments for stable DRG claims from the prior SFY.~~
 - b. ~~Subtotal each teaching hospital's fee-for-service inpatient acute covered charges from the prior SFY.~~
 - c. ~~Divide each teaching hospital's indirect medical education payments, as described in subsection a. above, by covered charges, as described in subsection b. above.~~
 - d. ~~Multiply the ratio described in subsection c. above times the covered charges in MCO paid claims for the rate period.~~
 - e. ~~Divide the amount calculated in subsection d. above by the number of MCO paid claims in the base year.~~

10-010.03B4 Calculation of ~~Stable DRG~~ Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis ~~for stable DRGs~~. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of stay for the ~~stable~~ DRG. Capital-related payment per diem amounts are calculated for Peer Group 1, 2, and 3 hospitals based on the Capital-related payment per diem amounts effective during SFY 2010.

The Base Capital-Related Cost Payments per diem amounts are described in 10-010.03B4 in effect on July 1, 2010. Each SFY the peer group specific capital-related payment per diem amounts shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The capital-related payment rates are adjusted annually and shall be effective each July 1.

~~10-010.03B5 Low Volume and Unstable DRG Payments: Discharges that are classified into a Low Volume or Unstable DRG are paid a Low Volume and Unstable DRG CCR payment and, if applicable, a DME payment. Low Volume and Unstable DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payment or Capital-Related Cost Payments.~~

10-010.03B5 (Reserved)

~~10-010.03B5a Low Volume and Unstable DRG: CCR Payments are calculated by multiplying the hospital-specific Low Volume/Unstable DRG CCR by Medicaid allowed claim charges.~~

~~On July 1 of each year, the Department will update the Low Volume/Unstable DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years. Each SFY Nebraska hospital-specific low volume and unstable DRG CCR payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The low volume and unstable DRG CCR payment rates are adjusted annually and shall be effective each July 1.~~

~~10-010.03B5b Low Volume and Unstable DRG DME Payments: Low Volume and Unstable DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation.~~

~~On July 1 of each year, the Department will update Low Volume and Unstable DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.~~

10-010.03B6 Transplant DRG Payments: Transplant discharges, identified as discharges that are classified to a transplant DRG, are paid a Transplant DRG CCR payment and, if applicable, a DME payment. Transplant DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B6a Transplant DRG CCR Payments: are calculated by multiplying the hospital-specific Transplant DRG CCR by Medicaid allowed claim charges.

On July 1 of each year, the Department will update the Transplant DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years.

Each SFY Nebraska hospital-specific transplant DRG CCR payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. ~~The low volume and unstable DRG CCR payment rates are adjusted annually and shall be effective each July 1.~~

10-010.03B6b Transplant DRG DME Payments: Transplant DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation.

On July 1 of each year, the Department will update Transplant DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.

10-010.03B7 (Reserved)

10-010.03B8 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1, 2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services shall not exceed 110 percent of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B8a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A final reconciliation will be made within 6 months following receipt by the Department of the facility's ~~final~~ settled cost report.

Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110 percent of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B9 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

10-010.03E3 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem as described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Payment for inpatient services of a CAH is ~~97.5 percent of~~ the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

10-010.03F1 Adjustment Based on Legislative Appropriations: ~~The starting point for the payment amounts, as determined in section 10-010.03F, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.~~

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for ~~Medicaid NMAP~~. This requirement does not apply to a hospital:
 - a. The inpatients of which are predominantly individuals under 18 years of age; or
 - b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.
 - c. For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. Only Nebraska hospitals which have a current enrollment with ~~the~~ Nebraska Medicaid ~~Assistance Program~~ will be considered for eligibility as a Disproportionate Share Hospital.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services using the same methods described in this regulation for in-state hospitals, except that out-of-state hospitals do not receive direct medical education cost payments or indirect medical education cost payments. Payments for services are determined by assigning out-of-state hospitals to the appropriate peer group. The peer groups are:

1. Metro Acute Care Hospitals: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare;
2. Rural Acute Care Hospitals: All other acute care hospitals;
3. 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 the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.
4. 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 the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.

For peer groups 1 and 3, operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the appropriate peer group capital per diem rate. The cost-to-charge ratios for out-of-state hospitals that meet the criteria for inclusion in the calculation of DRG ~~relative weights~~ at section 10-010.03B1a of this regulation are determined using the same method described for in-state hospitals in Section 10-010.03B of this regulation. The cost-to-charge ratios for all other out-of-state hospitals are the peer group average of in-state hospitals.

Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

Tiered rates as described in 471 NAC 10-010.03D1, will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payments for rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Payments for rehabilitation hospitals are based on average of the in-state hospital specific per diem rates for the appropriate type of service. Capital-related cost payments are made based on the in-state peer group capital per diem rate.

10-010.06 Payment for Outpatient Hospital and Emergency Room Services: ~~The starting point for the outpatient hospital and emergency services rate shall be~~ The Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Seventy-~~three~~ five (~~73~~ 75) percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The effective date of the cost-to-charges ratio is the first day of the month following the Department's receipt of the cost report. Each state fiscal year, the outpatient hospital and emergency services rate shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. Outpatient hospital and emergency services rates shall be effective each July 1.

Providers shall bill outpatient hospital and emergency room services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services at ~~97.5 percent of~~ the fee schedule determined by CMS. See 471-000-520.

~~The starting point for the outpatient hospital and emergency services rate shall be the rates in effect July 1, 2010. The outpatient hospital and emergency services rate shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The outpatient hospital and emergency services rate amounts are adjusted annually and shall be effective each July 1.~~

10-010.06A Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Payment for outpatient services of a CAH is ~~97.5 percent of~~ the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. NMAP The Department will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made at ~~97.5 percent of~~ the reasonable cost of providing these services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, NMAP the Department will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

10-003.06A1 Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.06A, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

10-010.06B Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to 471 NAC 26-005.

10-010.06C Payment for Outpatient Mental Health and Substance Abuse Services in a Hospital: Providers shall use HCPCS procedure codes when submitting claims to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

1. Level 1: The codes contained in the most recently published edition of the American Medical Association's Current Procedural Terminology (CPT); and
2. Level 2: Federally defined alpha-numeric HCPCS codes.

The Nebraska Medical Assistance Program (~~Medicaid~~) (~~NMAP~~) pays for covered outpatient mental health services, except for laboratory services, at the lower of –

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as –
 - a. The unit value multiplied by the conversion factor;
 - b. The maximum allowable dollar amount; or
 - c. The reasonable charge for the procedure as determined by ~~the~~ Medicaid ~~Division~~ (indicated as "BR" – by report or "RNE" – rate not established in the fee schedule).

HCPCS/CPT procedure codes used by ~~Medicaid NMAP~~ are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518 and 471-000-532).

10-010.06C1 Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to –

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when ~~Medicaid the Medical Services~~ ~~Division~~ determines that the current allowable amount is –
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

See 471 NAC 20-002.11 and 13 and 471 NAC 32-002.11 and 15.

10-010.06D Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for an emergency medical condition, (see emergency medical condition in 471 NAC 10-001.02);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by his or her physician for treatment in an emergency room.

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency medical condition and bill accordingly.

When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of what would otherwise be allowed. All other Medicaid allowable charges incurred in this type of visit will be paid ~~at 73 percent of the ratio of cost to charges according to 471 NAC 10-010.06.~~

10-010.06E Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as state fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

10-010.06F Payment to a New Hospital for Outpatient Services: See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (a new operational facility) will be made at ~~73 percent of~~ the statewide average ratio of cost to charges for Nebraska hospitals as determined by the Department according to 471 NAC 10-010.06. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department ~~using 73 percent of the statewide average ratio of cost to charges according to 471 NAC 10-010.06.~~

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 et seq.)

10-010.06G Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges ~~for all Nebraska hospitals. times 73 percent for all Nebraska hospitals.~~ See 471 NAC 10-010.06.