CHAPTER 12-000 NURSING FACILITY SERVICES

12-001 Introduction: This chapter deals with Medicaid coverage of services provided in nursing facilities (NF's). It includes Senior Care Options, Nebraska's preadmission screening.

12-001.01 Purpose

12-001.01A Nursing Facility: The Nebraska Medical Assistance Program (NMAP) covers nursing facility services to help clients attain or retain their capacity for independence or self-care in the least restrictive environment by providing payment -

1. For the most appropriate and cost-effective medical care necessary to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident;
2. To facilities licensed and certified in Nebraska by the Department of Health and Human Services Regulation and Licensure, or to facilities licensed and certified in other states; and
3. For medical assistance provided to institutionalized medically and categorically needy clients whose financial resources are insufficient to meet the cost of medically necessary care.

12-001.01B Senior Care Options (SCO): The purpose of Senior Care Options is to assure appropriate utilization of nursing facility services which are funded through the Nebraska Medical Assistance Program, Medicaid, and to offer service choices. SCO evaluates the care needs of each person, age 65 or older, who has requested Medicaid coverage of nursing facility care to determine if such care is needed, according to set criteria. That determination affects eligibility for Medicaid coverage of nursing facility services and services provided through the Aged and Disabled Home and Community-Based Waiver Program.

12-001.01C Preadmission Screening Process (PASP): When an individual requests admission to or continuous residence in a Medicaid-certified bed in a nursing facility, the facility shall implement the Preadmission Screening Process (PASP) as defined in this chapter. An individual who has an indication or diagnosis of mental illness, mental retardation or a related condition, or a dual diagnosis may be admitted to a nursing facility or continue to reside in a nursing facility only when the individual is determined to be appropriate for nursing facility services through the PASP.

The PASP provides the following to an individual with a diagnosis or indication of mental illness, mental retardation or a related condition, or a dual diagnosis:

1. A determination whether the individual has mental illness, mental retardation or a related condition, or a dual diagnosis;
2. A determination whether the level of services provided by a nursing facility is appropriate to meet the individual's needs; and
3. A recommendation for services that addresses the individual's need(s) in a nursing facility or in an alternative placement (without regard to the availability of services).

12-001.02 Legal Basis: The Nebraska Medical Assistance Program (NMAP) was established under Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Section 68-1018, R.R.S. 1943.

Section 1919 of the Social Security Act specifically addresses requirements for nursing facilities under the Medicaid program, including the preadmission screening process.

Section 81-2265 through 2271, Reissue Revised Statutes of Nebraska, 1943, mandates preadmission screening, the program operating as Senior Care Options.

42 CFR Part 483 contains the requirements for long term care facilities participating in the Medicaid program.

12-001.03 Definitions of Facility Types: Under federal regulations, the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution (42 CFR 483.5). The following facility definitions apply within this chapter.

Acute Medical Hospital: An institution that -

1. Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
2. Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
3. Meets the requirements for participation in Medicare as a hospital; and
4. Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30.

Intermediate Care Facility for the Mentally Retarded (ICF/MR): A facility that -

1. Meets the standards for licensure as established by the Nebraska Department of Health and Human Services Regulation and Licensure and all related requirements for participation as prescribed in federal law and regulations governing medical assistance under Title XIX of the Social Security Act;
2. Is certified as a Title XIX ICF/MR under Medicaid; and
3. Has a current provider agreement with the Nebraska Medical Assistance Program and a Department of Health and Human Services Regulation and Licensure certification and transmittal (Form HCFA-1539) on file with the Nebraska Department of Health and Human Services Finance and Support.

Nursing Facility (NF): A facility (or a distinct part of a facility) that -

1. Meets the standards for hospital, skilled nursing, nursing facility, or intermediate facility licensure established by the Nebraska Health and Human Services Regulation and Licensure and all related requirements for participation as prescribed in federal law and regulations governing medical assistance under Title XIX of the Social Security Act;

2. Is certified as a Title XIX NF under Medicaid (may also be certified as a Title XVIII SNF under Medicare);
3. Provides 24-hour, seven-day week RN and/or LPN services (full-time R.N. on day shift) unless the Nebraska Department Health and Human Services Regulation and Licensure has issued a staffing waiver (see definition of "waivered facility" in 471 NAC 12-001.04); and
4. Has a current NMAP provider agreement and a Certification and Transmittal (Form HCFA-1539) on file with the Department.

Skilled Nursing Facility (SNF) (Medicare): A facility (or distinct part) that -

1. Meets the standards for hospital or skilled nursing licensure established by the Nebraska Department of Health and Human Services Regulation and Licensure and all related requirements for participation as prescribed in federal law and regulations governing medical assistance under Title XIX of the Social Security Act;
2. Is certified as a Title XVIII SNF under Medicare (may also be certified as a Title XIX NF under Medicaid).

Medicare Distinct Part Facility: Some facilities have a "distinct part" which participates only in the Medicaid program as an NF and another "distinct part" which participates only in the Medicare program. In such cases the Medicaid distinct part is subject to the PASP requirements and the Medicare part is not. If the beds are dually certified as both Medicaid and Medicare, PASP screening processes are required because of the Medicaid participation. Likewise, a nursing facility participating solely in the Medicare program as a SNF (with no Medicaid certification) is not subject to Level I or Level II screening through PASP.

12-001.04 Definitions of Terms: The following definitions apply within this chapter.

Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Admission means an admission applies to an individual who -

1. Has never resided in the nursing facility;
2. Has been formally discharged from one nursing facility and is being admitted to a different facility; or
3. Has been formally discharged, return not anticipated from a previous stay, by the admitting facility.

Each admission as defined above requires a new prior authorization.

For prior authorization purposes, NF to NF transfer is considered a new admission and requires a new prior authorization. For admissions that require preadmission screening under PASP, see 471 NAC 12-004.

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 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 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).

Community-Based Developmental Disability Services (CBDDS) means an array of services for persons with mental retardation or a related condition, including vocational, pre-vocational, residential, and case management services, provided outside an institutional setting.

Community-Based Developmental Disability Service Provider (CBDDSP) means any public or private agency that provides services for persons with mental retardation or a related condition in a community setting.

Community-Based Mental Health Services (CBMHS) means an array of mental health services, including residential, day rehabilitation, vocational support, and service coordination.

Community-Based Waiver Services For Adults With Mental Retardation or Related Conditions means an array of community-based services to individuals who are eligible for ICF/MR services under the Nebraska Medical Assistance Program. The purpose of the waiver services is to offer options to Medicaid clients who would otherwise require ICF/MR services.

Community Mental Health Region (CMHR) means community mental health programs divided geographically into mental health regions to organize and facilitate the delivery of community mental health services.

Dementia means sole diagnoses of dementia or related disorders (e.g., Alzheimer's disease) are exempt from PASP psychiatric evaluations. If the individual has a dual condition of a serious mental illness, as defined in this section, in conjunction with a dementia, the dementia must be determined as the primary psychiatric disorder for the exemption to occur. "Primary" means that the symptoms of the dementia supersede symptoms of any concurrent psychiatric condition. Individuals with mental retardation or related conditions may be eligible for a more abbreviated screen, referred to as a categorical determination, based upon an analysis of the presenting data. Federal regulation requires that a reasonable effort must be made to confirm the dementia as predominant and primary. Confirmation can occur through provision to HHS/contractor of appropriate testing (i.e., CT scans) and/or assessments (e.g., neurological, neuro-psychiatric) and/or mental status data which confirms the primary ranking of the dementing condition. Social history information, physician notes, etc., can also be used if the information supports a "reasonable effort" and effectively confirms the positioning of the dementia diagnosis as primary.

Discharge Plan means a plan developed by the interdisciplinary team at the time of admission which identifies -

1. The rationale for the client's current level of care;
2. The types of services the client would require in an alternate living environment; and
3. The steps to be taken for movement to a less restrictive living environment. (42 CFR 483.20).

Dual Diagnosis means for PASP purposes, an individual is considered to have a dual diagnosis of mental illness and mental retardation if s/he has a primary or secondary diagnosis in each category according to the definitions found in this chapter.

HCFA means health Care Financing Administration. Note: HCFA has been renamed and is now known as Centers for Medicare and Medicaid Services (CMS).

Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities means an array of community-based services available to individuals who are eligible for NF (Nursing Facility) services under the Nebraska Medical Assistance Program but choose to receive services at home. The purpose of the waiver services is to offer options to Medicaid clients who would otherwise require NF services.

HHS F&S means the Nebraska Department Health and Human Services Finance and Support.

Inpatient Psychiatric Hospital means a psychiatric hospital or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Institution for Mental Diseases (IMD) means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical care, nursing care, and related services (42 CFR 440.140(a)(2)). Medicaid reimbursement for IMDs is limited to individuals age 65 and older and age 20 and younger.

Interdisciplinary Team means a group of persons (as determined by the Department of Health and Human Services Finance and Support (HHS F&S) standards for each level of care) who meet to identify the needs of the client and develop an integrated comprehensive plan of care to accomplish these needs.

Legal Representative means any person who has been vested by law with the power to act on behalf of an individual. The term includes a guardian appointed by a court of competent jurisdiction in the case of an incompetent individual or minor, or a parent in the case of a minor, or a person acting under a valid power of attorney.

Level I Evaluation means completion of Form HHS-OBRA1, "Identification Screen," for all admissions to a nursing facility. A Level I evaluation must be completed before an individual is admitted to a nursing facility to determine whether there is an indication or diagnosis of mental illness, mental retardation or a related condition, or a dual diagnosis.

Level II Evaluation means completion of an assessment of any individual who has a diagnosis or indication of mental illness, mental retardation or a related condition, or a dual diagnosis.

Local Office means the Department of Health and Human Services office in the county where the client, or the guardian or conservator if applicable, resides.

Maintenance Therapy means therapy to maintain the client at current level and/or to prevent loss or deterioration of present abilities.

Medicaid means medical assistance provided under a state plan approved under Title XIX of the Social Security Act also known as the Nebraska Medical Assistance Program.

Medicaid Aged and Disabled Waiver means see "Home and Community-Based Waiver Services for Aged Persons or Adults/Children with Disabilities." 480 NAC Chapter 5.

Medicaid-Eligible means the status of a client who has been determined to meet established standards to receive benefits of Medicaid.

Medical Review means Program Specialist/R.N.'s located in the Medicaid Division, Central Office, with physician consultation.

Medicare means the federal health insurance program for persons who are aged or have disabilities under Title XVIII of the Social Security Act.

Mental Health (MH) Services means for purposes of PASP, an array of services that are less intensive than specialized services. These services are determined by sources such as a physician, the PASP Final Determination, the resident assessment process (MDS) and the individual's comprehensive plan of care, or an individual program plan. They may include medication monitoring, counseling and therapy, consultations with a psychiatrist, and/or mental health interventions. The nursing facility is responsible for providing mental health services.

Mental Retardation means "mental retardation" refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. A PASP should be performed on any nursing facility applicant or resident with a suspected or known diagnosis of mental retardation or a related condition.

Mental Retardation/Related Condition (MR/RC) Services means for purposes of PASP, an array of services that are less intensive than specialized services. These services are determined by sources such a physician, the PASP Final Determination, the resident assessment process (MDS) and the individual's comprehensive program plan, or an individual program plan. They may include occupational therapy, physical therapy, speech pathology and audiology, assistive devices, and/or mental retardation/related condition interventions. The nursing facility is responsible for providing mental retardation/related condition services.

Minimum Data Set (MDS) means a federally-required interdisciplinary assessment completed according to the federally-designated schedule for every nursing facility resident.

Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

NMAP means the Nebraska Medical Assistance Program (Nebraska's Medicaid program).

Negative ID Screen means the results of a Level I evaluation that indicates the individual does not require a Level II evaluation.

Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Neurological Examination: For purposes of PASP, a neurological examination may consist of the following components:

1. Mental status exam. A mental status exam usually contains the following components:
   a. Appearance - age, grooming, posture, motor activity, stature (height and weight).
   b. General behavior - cooperative, withdrawn, apathetic, suspicious, aggressive, compliant, histrionic, anxious, relaxed, hostile.
   c. Affect and Mood - appropriate, flat, labile, sad, elated, angry, inappropriate.
   d. Thought Processes - logical, circumstantial, dissociated, obsessive, phobic, suicidal, flight of ideas, ideas of reference.
   e. Perception - illusions, hallucinations, delusions.
   f. Cognitive Functions - level of awareness (orientation to time, place, and person), attention and concentration, memory (remote and recent), judgment and insight.
2. Client's muscle strength and movements.
3. Pupillary reaction in terms of time and uniformity.
4. Coordination and balance.
5. Sensory abilities.
6. Lumbar and cisternal punctures as needed to detect blockage or central nervous system infection - such as meningitis, syphilis, or multiple sclerosis.
7. Myelography to diagnose a tumor, herniated disc, or other cause of nerve or spinal cord compression.
8. Brain scans and CT scans to discover causes of difficulties thought to be of cerebral origin.
9. Angiography to determine cause of motor weakness, stroke, seizure or intractable headaches.
10. EEG to detect brain tumors, infections, dementias and information concerning the cause and type of seizure disorder.
11. Electromyography to assist in diagnosing muscular dystrophy and myasthenia gravis or polyneuropathy.

For purposes of PASP, the neurological examination may be completed by an M.D. The physician's findings must be clearly substantiated and must focus on a physical examination and a psychological examination (mental status/cognitive functioning). Although a neurological examination on its own may corroborate a diagnosis of dementia, these examinations are not determinative alone. Other factors may be considered.

Nurse Aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietician, or someone who volunteers to provide such services without pay.

OCMH means office of Community Mental Health.

PASP means preadmission Screening Process, required by the Social Security Act.

Physician's Certification means the physician's determination that the client requires the nursing facility level of care.

Positive ID Screen means results of a Level I screen which indicate that an individual falls within federal requirements for a mandatory Level II preadmission and annual evaluations.

Preadmission Screening Process means a federal assessment process required of all applicants to and residents of Medicaid certified nursing facilities who, through a positive Level I ID screen, have been determined to have mental illness and/or mental retardation/related conditions. For individuals within MI/MR/RC, the purpose is to determine if an individual with a serious mental illness diagnosis, a mental retardation or a related condition diagnosis is appropriate for NF care, and does not require inpatient psychiatric treatment or equally intensive services; ICF/MR services; community-based mental health, mental retardation or developmentally disabled services, or alternative services.

Prior Authorization means authorization of payment for nursing facility services based on determination of necessity for nursing facility services.

Private Pay means an individual who does not meet the Medicaid eligibility requirements but who, if applying to or residing in a Medicaid certified NF, is subject to mandatory PASP Level I/II screening, as applicable.

Professional Services means services provided by, or under the direct supervision of professional personnel (e.g., physician services or nursing care by an RN or LPN).

Psychological Evaluation means for PASP purposes, a psychological evaluation is required as part of a Level II evaluation for an individual with an indication or diagnosis of mental retardation or a related condition, or a dual diagnosis. The psychological evaluation must be current within three years. A psychological evaluation that is not current within three years may be accepted if the individual has been in CBDDSP since the evaluation was completed. The evaluation must address the individual's intellectual functioning and validate the diagnosis of mental retardation or a related condition. The psychological evaluation report must include the following information:

1. Type of test(s) administered to determine IQ score and adaptive behavior functioning;
2. Test scores;
3. Interpretation of the findings;
4. Recommendation;
5. Diagnosis;
6. Discussion of any other diagnosis and tests used to substantiate these findings; and
7. Summary of adaptive and functional levels.

Psychologist means for PASP purposes, the psychological evaluation must be completed by a psychologist who meets one of the following criteria:

1. A licensed psychologist;
2. A licensed and certified clinical psychologist;
3. A certified psychologist (MS) in a clinical setting - a psychological evaluation completed by certified psychologist must be counter-signed by a licensed and certified clinical psychologist;
4. A certified counselor (MA) - a certified counselor can only complete psychological evaluations as specified by the Department of Health and Human Services Regulation and Licensure's Bureau of Examining Board.

All licensure and certifications must be current and approved according to the Department of Health and Human Services Regulation and Licensure requirements.

Psychoactive Medication means medications used to ameliorate the principal symptoms that occur in persons with mental illness.

Qualified Mental Retardation Professional (QMRP) means an individual who meets the qualifications as defined in 42 CFR 483.430 and who has completed the required training by the FMH may complete specified portions of the PASP. See 471-000-233 for the QMRP qualifications.

Readmission means for PASP, an individual qualifies as a readmission if s/he was readmitted to a facility from an acute medical hospital to which s/he was transferred for the purpose of receiving care. Readmissions which fall within the State's bedhold policy are subject to the Resident Review/Status Change process rather than the Preadmission Screening process. An individual returning to the same or another facility after an absence greater than the State's bedhold policy are subject to Level I and Level II Preadmission Screening requirements, if applicable. Readmissions following psychiatric hospitalizations, regardless of whether the hospitalization occurs in a medical hospital psychiatric unit or a regional psychiatric hospital and regardless of whether the absence falls within the State's bedhold policy, are subject to preadmission Level I/II screening requirements, as applicable.

Rehabilitation means provision of services to promote restoration of the client to his/her former level of functioning.

Rehabilitative Services means services provided by or under the supervision of licensed or certified medical personnel, e.g., physical therapist, occupational therapist, respiratory therapist, speech pathologist, and audiologist.

Related Condition means an individual is considered to have a related condition, as defined by 42 CFR 435.1009, when the individual has a severe, chronic disability that meets all of the following conditions:

1. It is attributable to -
   a. Cerebral palsy or epilepsy; or
   b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons;
2. It is manifested before the person reaches age 22;
3. It is likely to continue indefinitely;
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
   a. Self-care;
   b. Understanding and use of language;
   c. Learning;
   d. Mobility;
   e. Self-direction;
   f. Capacity for independent living.

Restorative Therapy means therapy which restores the client to his/her original functional capacity or to the highest level possible if the original level cannot be attained.

Senior Care Options means Nebraska's nursing facility preadmission screening program for aged persons and Aged and Disabled Waiver services coordination system for Medicaid eligible persons who choose to explore home care.

Serious Mental Illness (SMI) means for PASP purposes, an individual is considered to have a serious mental illness and require a PASP Level II evaluation if s/he meets all of the following three qualifiers:

1. Diagnosis Qualifier: The individual has a psychiatric diagnosis which, by accepted clinical standards, is determined to be a serious and persistent psychiatric condition, diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition or its revisions. The mental disorder must be characterized as likely to lead to a chronic disability but cannot be a primary psychiatric diagnosis of dementia or a related disorder. For the purpose of this definition, Alzheimer's and organic disorders are considered related disorders to dementia. If dementia or a related disorder co-exists with a serious and persistent mental illness which is not a dementia, the dementia or related disorder must be predominant and progressive to exempt the co-occurring psychiatric condition from this qualifier.

In circumstances of co-occurring primary dementia and a serious mental illness, federal language requires that a reasonable effort must be made by the Level I screening agency to confirm the dementia as predominant and primary. Confirmation can occur through provision of appropriate testing (i.e., CT scans) and/or assessments (e.g., neurological, neuro-psychiatric) and/or mental status data which confirms the primary ranking of the dementing condition. Social history information, physician notes, etc., can also be used if the information supports a "reasonable effort" and effectively confirms the positioning of that diagnosis.

2. Disability/Level of Impairment Qualifier: Within the past six months, the psychiatric disorder has resulted in functioning limitations in one or more of the following major life activities on a continuing or intermittent basis:
   a. Serious difficulty interacting appropriately and communicating effectively with other persons. Examples of such difficulty may include but are not limited to possibly history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation;
   b. Serious difficulty sustaining focused attention for a sufficient period of complete tasks for which s/he should be medically capable. Examples of such difficulty may include but are not limited to concentration difficulties, inability to complete simple tasks within an established time frame, frequent errors related to task completion, or need for assistance in completion of tasks; or
   c. Serious difficulty adapting to typical changes in circumstances. Examples of such difficulty may include but are not limited to agitation, exacerbated signs and symptoms of the psychiatric condition, withdrawal from the situation, or need for intervention by the mental health or judicial system.
3. Duration/Recent Treatment Qualifier: The treatment history indicates that the individual has experiences at least one of the following:
   a. Psychiatric treatment more intensive than outpatient care (e.g., partial hospitalization, inpatient psychiatric hospitalization, crisis unit placement) once within the past two years for a nursing facility resident or more than once in the past two years for a nursing facility applicant.
   b. Within the past two years, due to the mental disorder, experienced a major episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials. For the purpose of this definition, major episode of significant disruption may include an involuntary psychiatric hospitalization, suicidal attempts or gestures, 1:1 monitoring, and/or other issues which are safety-related or involved.
   c. Residence in a nursing facility which provides intensive psychiatric services beyond that which is provided in a typical NF environment.
   d. Within the past two years, residence in a psychiatric hospital which required a period of hospitalization greater than that which is typically required for acute stabilization (e.g., inpatient psychiatric hospitalization extending beyond 30 days).

Specialized Services For Individuals with Mental Illness means services which result in the continuous and aggressive implementation of an individualized plan of care that -

1. Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals, and, as appropriate, other professionals;
2. Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
3. Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his/her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

These services are commonly provided in an IMD facility, inpatient psychiatric facility, or an equally intensive facility, e.g., crisis unit.

Specialized Services for Individuals with Mental Retardation or a Related Condition means a continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards -

1. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and
2. The prevention or deceleration of regression or loss of current optimal functional status.

These services are commonly provided in an ICF/MR or in a community-based developmental disability services (CBDDS) program.

Specialized services do not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous specialized services program. Specialized services may include services provided in an ICF/MR setting or in a community-based developmental disability services (CBDDS) program and are provided for: residents determined to have medical needs which are secondary to developmental/habilitative needs and who do not meet NF medical necessity standards. Specialized service options include:

1. Assessment/evaluation for alternative communication devices;
2. Behavior management program;
3. Day program;
4. Vocational evaluation;
5. Psychological/psychiatric evaluation;
6. Stimulation/environmental enhancements or use of assistive devices.

With the exception of day program, these services are considered rehabilitative, rather than specialized, for these residents meeting medical necessity standards for nursing facility placement.

Status Change means a major change in the NF resident's status that -

1. Is not self-limiting. A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions;
2. Impacts on more than one area of the resident's physical or mental health status; and
3. Require interdisciplinary review or revision of the care plan.

Summary Note/Final Recommendation means the summary and recommendation for services that addresses -

1. The individual's diagnoses, medical, physical, functional, and psychosocial strengths/needs, etc.;
2. The individual's need for any further evaluation;
3. Recommendations for treatment and/or service needs and any referrals determined to be appropriate; and
4. A summary of the findings and recommendation for services.

The summary note/final recommendation must be based on a compilation of supportive information provided by the facility, physician, mental health reviewer, and QMRP through the PASP process.

Swing Bed Facility means a rural acute hospital which is certified to provide a skilled nursing facility level of care as defined in 471 NAC 12-009.08 and 10-014 ff. Admission to a swing bed is not subject to PASP.

Terminally Ill means as defined in Section 1861(dd)(3)(A) of the Social Security Act, a person is considered to be terminally ill if s/he has a medical prognosis that his/her life expectancy is six months or less. For persons with mental illness, mental retardation or a related condition, or a dual diagnosis who are found to be suffering from a terminal illness, the nature and extent of the individual's need for nursing services and medical supervision and treatment is considered the determining factor, while the existence of a chronic mental or physical disability is treated as an incidental consideration.

30-Month Choice means a choice provided to an individual based on 30 months of continuous residence in an NF from time of admission to NF care to the date of the Level II evaluation. The resident does not necessarily have to reside in the same nursing facility to meet the 30-month continuous residency requirement, but must reside in an NF bed. Temporary absences from a nursing facility for inpatient hospital treatment for less than six months are not considered a break in residence. This choice does not apply to an individual with a serious mental illness who requires specialized services.

Validating Professional means the medical professional who diagnoses mental illness according to DSM-III-R criteria and determines whether a program of specialized services is needed. This may be a board-eligible or board-certified psychiatrist or a licensed and certified clinical psychologist who meet the licensure/certification requirements of the Nebraska Department of Health and Human Services Regulation and Licensure, depending upon the expertise needed by the Mental Health Reviewer to complete the comprehensive assessment and make the required service recommendations. If the validating professional is the mental health reviewer, s/he may complete both functions.

Waivered Facility means a nursing facility that has received a waiver of licensed nursing staff requirements from the Department of Health and Human Services Regulation and Licensure.

12-002 Standards for Participation for Nursing Facilities: The NF shall meet -

1. The Nebraska nursing home licensure, and Medicare/Medicaid certification standards as required by state statutes and 42 CFR 483, Subpart B, or if located outside of Nebraska, similar standards in that state;
2. The HHS F&S facility type, program and operational definitions, and criteria contained in the Nebraska Department of Health and Human Services Finance and Support Manual; and
3. The definition of a nursing facility (NF) as defined in 471 NAC 12-001.03, and in section 1919 of the Social Security Act.

12-002.01 Provider Agreement: To participate in the Nebraska Medical Assistance Program (NMAP), the nursing facility shall meet the standards in 471 NAC 12-002 and shall complete Form MC-81, "Medical Assistance SNF/ICF/ICF-MR Provider Agreement" (see 471-000-104). The facility submits the completed and signed form to the Medicaid Division for approval and enrollment as a provider.

12-002.02 Nurse Aides

12-002.02A General Rule: An individual may be employed by a certified facility as a nurse aide only if all of the following requirements have been met:

1. That individual is competent to provide nursing and nursing-related services;
2. The nurse aide has met the training and competency requirements found at 42 CFR 483.75, 150 and 154, or that individual has been deemed or determined competent as provided in 42 CFR 483.150;
3. The nurse aide has met the requirements set out in Neb. Rev. Stat. Section 71-6038 and 6039; and
4. The nurse aide has not -
   a. Been found guilty of abusing, neglecting, or mistreating residents by a court of law; or
   b. Had a finding entered into the State nurse aide registry concerning abuse, neglect, or mistreatment of residents or misappropriation of their property under the provisions of 471 NAC 12-002.03.

12-002.02B Facility Responsibility

12-002.02B1 Registry Verification: Before allowing an individual to serve as a nurse aide, a facility shall contact the State nurse aide registry and verify that the individual has met competency evaluation requirements unless -

1. The individual is a full-time employee currently participating in a training and competency evaluation program approved by the State; or
2. The individual can prove that s/he has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities shall follow up to ensure that the individual actually becomes registered.

12-002.02B2 Multi-State Registry Verification: Before allowing an individual to serve as a nurse aide, a facility shall seek information from every State nurse aide registry the facility believes will include information on the individual.

12-002.02B3 Duty to Report: A facility shall report any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

12-002.03 Nurse Aide Requirements

12-002.03A Purpose: This section incorporates the requirements of 42 CFR 483.13, 75, 150, 151, 152, 154 and 156; and 42 CFR 488.332 and 335, effective as of October 1, 1995, regarding nurse aides and the nurse aide registry.

12-002.03B State Approval of Nurse Aide Training and Competency Programs: Pursuant to federal requirements found at 42 CFR 483.151 and 42 CFR 483.152 and State statute, the State approves training and competency programs for nurse aides. Those provisions are found at Neb. Rev. Stat. Section 71-6039.

12-002.04 Establishment of Nurse Aide Registry

12-002.04A Purpose: A registry of nurse aides is established and maintained by the State for the purpose of providing a central data bank of individuals who are eligible to function as nurse aides in certified facilities. The State Medicaid agency contracts with the State Survey and Certification agency to operate and maintain the registry.

12-002.04B Registry Eligibility: The registry must comply with the following:

1. To be included on the nurse aide registry as eligible to function as a nurse aide, an individual shall meet the requirements in 471 NAC 12-002.02, including having no adverse findings of abuse, neglect, or misappropriation of property of a resident on the nurse aide registry;
2. An individual may be deemed or determined competent for eligibility for placement on the registry as provided in 42 CFR 483.150;
3. Adverse findings of abuse, neglect, or misappropriation of property are placed on the registry after a determination by the State survey and certification agency; and
4. No monetary charges related to registration of individuals on the registry are imposed.

12-002.04C Registry Content: The registry contains the following information on each individual who has successfully completed a nurse aide training and competency evaluation program, or who has completed a competency evaluation and has been found to be competent to function as a nurse aide pursuant to 471 NAC 12-002.02:

1. The individual's full name;
2. Information necessary to identify each individual;
3. The date the individual became eligible for placement in the registry;
4. With a finding of abuse, neglect, or misappropriation of property by the individual, the following information is included:
   a. Documentation of the investigation, including the nature of the allegation and the evidence that led to the conclusion that the allegation was valid;
   b. If the individual chose to have a hearing, its date and outcome; and
   c. If the individual chooses to dispute the allegation, his/her statement;
5. Information related to the provisions of 471 NAC 12-002.03A, items 3 and 4a; and
6. Documentation of the ineligibility of individuals who have performed no nursing or nursing-related services for a period of 24 consecutive months.

Note: The information identified in item 4 is placed on the registry within ten working days of the finding and remains on the registry permanently, unless the finding was made in error, the individual was found not guilty in a court of law, or the State is notified of the individual's death.

12-002.04D Removal of Findings of Neglect from Nurse Aide Registry: In the case of a finding of neglect under 471 NAC 12-002.02.04B, a Nurse Aide may peition the State survey and certification agency in writing, to have the findings removed from the registry provided that:

1. The employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and
2. The neglect involved in the original finding was a singular occurrence; and
3. More than one year has lapsed since the finding of neglect was added to the nurse aide registry.

12-002.04D1 Content of Petition: Petitions may be submitted on a form provided by the Department, or may be submitted in other written format as long as the petition includes the following:

1. The subject matter of the petition;
2. Employment history;
3. A signed release of information for employer references;
4. A statement indicating why the petitioner believes the findings of neglect should be removed from the registry;
5. Information regarding any education or rehabilitation efforts that the individual has completed since the finding of neglect was placed on the registry; and
6. Fee, as established by the State Patrol, for the State survey and certification agency to request a criminal background check.

12-002.04D2 Review of Petition: The State survey and certification agency will:

1. Contact past employers to determine if the petitioner had any documented incidents of abusive or neglectful behavior during his/her employment as a nurse aide that resulted in any employment action including counseling;
2. Request the State Patrol to conduct a review of records to determine if criminal conviction information is recorded;
3. Review the petition and all other requested information to determine whether the petitioner's findings of neglect should be removed from the registry. Consideration will be given to the following factors in making the determination:
   a. The amount and degree of neglect involved in the original incident;
   b. The severity of the potential negative resident outcome;
   c. The severity of the actual negative resident outcome;
   d. The opinion of the individual's employer at the time of the incident regarding removing the finding from the registry, including the employer's willingness to rehire the individual;
   e. Any rehabilitation or education completed by the individual since the incident;
   f. Employer reports, to ensure a majority do not identify personal action taken regarding abusive or neglectful behavior; and
   g. The criminal background report to determine if there is a history of mistreatment findings, including instances of domestic abuse, the granting of a restraining order whih has not been overturned, or any conviction of any crime involving violence or the threat of violence.

12-002.04D3 Review Outcome: Based on factors identified in 471 NAC 12-002.04D2, item 3, the State survey and certification agency may -

1. Remove the finding from the registry;
2. Require the individual to demonstrate successful completion of a state-approved nurse aide training and competency evaluation program prior to the finding being removed from the registry;
3. Require the individual to complete a rehabilitation or education program prior to the finding being removed from the registry; or
4. Implement any combination of the above sanctions.

12-002.04D4 Notification:

1. If the State survey and certification agency determines the findings of neglect should be removed from the nurse aide registry, the petitioner will be notified in writing within 150 days of receipt of the petition.
2. If the State survey and certification agency determines the findings of neglect should not be removed from the registry or the actions identified in 471 NAC 12-002.04D3, items 2-4 must be completed prior to removal of the findings, the individual will be notified in writing within 150 days of receipt of the petition of their right to request a hearing to contest the determination. Hearings must be requested in writing within 30 days from the state of the denial notice. Hearings will be conducted in accordance with 471 NAC 12-002.05C.
3. If a new finding of neglect is placed on the individual's registry listing after the previous finding of neglect has been removed, the new finding will remain on the registry permanently with no opportunity for review.

12-002.04E Disclosure of Information: Information in 471 NAC 12-002.04C, items 3 & 4, is disclosed to all requesters. Information in 471 NAC 12-002.04C, items 3 & 4, is -

1. Provided to the individual affected when adverse findings on him/her are placed in the registry, or
2. Provided to the individual upon his/her request. Individuals on the registry must have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

12-002.05 Investigation of Complaints and Placement of Adverse Findings

12-002.05A Review of Allegations: The State survey and certification agency reviews all allegations of resident neglect and abuse, and misappropriation of resident property by nurse aides.

1. If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident or misappropriated a resident's property, the State investigates the allegation.
2. The State reviews all allegations regardless of their source.

12-002.05B Notification: If the State survey and certification agency makes a preliminary determination, based on oral or written evidence and its investigation, that the abuse, neglect or misappropriation of property occurred, the following are notified in writing within ten working days of the State's survey and certification agency's investigation:

1. The individuals implicated in the investigation; and
2. The current administrator of the facility in which the incident occurred.

12-002.05B1 Content of Notice: The notice includes the following:

1. The nature of the allegation;
2. The date and time of the occurrence;
3. The right to a hearing;
4. The survey and certification agency's intent to report the substantiated findings in writing, once the individual has had the opportunity for a hearing, to the nurse aide registry or appropriate licensure authority;
5. The fact that the individual's failure to request a hearing in writing within 30 days from the date of the notice will result in the survey and certification agency reporting the substantiated findings to the nurse aide registry or appropriate licensure authority;
6. The consequences of waiving the right to a hearing;
7. The consequences of a finding through the hearing process that the alleged resident abuse or neglect, or misappropriation of resident property did occur; and
8. The fact that the individual has the right to be represented by an attorney at the individual's own expense.

12-002.05C Conduct of the Hearing and Judicial Review: The hearing is conducted under the following provisions:

1. The hearing and the hearing record are completed within 120 days from the day the State survey and certification agency receives the request for a hearing;
2. The hearing is held at a reasonable place and time convenient for the individual;
3. The hearing will be conducted in accordance with the provisions of the Nebraska Administrative Procedures Act; and
4. Any individual aggrieved by a final decision following a hearing may seek judicial review of that decision. Procedures for said review are governed by the provisions of the Nebraska Administrative Procedures Act.

12-002.05D Factors Beyond the Individual's Control: A finding that an individual has neglected a resident will not be made if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

12-002.05E Report of Findings: If the finding is that the individual has neglected or abused a resident or misappropriated resident property or if the individual waives the right to a hearing, the State survey and certification agency, which may not delegate this responsibility, reports the findings in writing within ten working days to the following:

1. The individual;
2. The current administrator of the facility in which the incident occurred;
3. The administrator of the facility that currently employs the individual, if different that the facility in which the incident occurred;
4. The licensing authority for individuals used by the facility other than nurse aides, if applicable; and
5. The nurse aide registry for nurse aides. The findings must be included in the registry within ten working days of the findings, in accordance with 471 NAC 12-009.03.

12-003 Nursing Facility Level of Care (NF LOC) Criteria: The client or his or her authorized representative must provide information needed to determine Nursing Facility Level of Care (NF LOC). This information may include in-person discussion and observation of the client; reports from caregivers, family, and providers; and, current medical records. Information is gathered on Activities of Daily Living (ADL), Risk Factors, Medical Conditions and Interventions, and Cognitive Function.

12-003.01 Level of Care Determination for Adults: Medicaid eligibility determinations must be made on admission and any subsequent review. A client must satisfy one of the four following categories to meet Nursing Facility Level of Care (NF LOC) eligibility:

1. A limitation in at least three Activities of Daily Living (ADL) (see 471 NAC 12-003.01A1) and one or more risk factors (see 471 NAC 12-003.01A2);
2. A limitation in at least three Activities of Daily Living (ADL) (see 471 NAC 12-003.01A1) and one or more medical treatments and interventions (see 471 NAC 12-003.01A3);
3. A limitation in at least three Activities of Daily Living (ADL) (see 471 NAC 12-003.01A1) and one or more areas of cognitive limitation (see 471 NAC 12-003.01A4); or
4. A limitation in at least one Activities of Daily Living (ADL) (see 471 NAC 12-003.01A1) and at least one risk factor (see 471 NAC 12-003.01A2) and at least one area of cognitive limitation (see 471 NAC 12-003.01A4).

12-003.01A Activities of Daily Living (ADL): Information about limitations in Activities of Daily Living (ADL) is obtained from observation of the client in the home setting, reports from guardians/caregivers, and current medical records. Activities of Daily Living (ADL) are considered a limitation when the client, due to his or her physical or cognitive disabilities, requires physical assistance or supervision from another person on a daily basis to initiate or complete the tasks associated with each Activities of Daily Living (ADL) defined in this section. For the purposes of this section (471 NAC 12-003.01A1), the term "ability" shall be interpreted to include the physical ability, cognitive ability and endurance necessary to complete identified activities. The following Activities of Daily Living (ADL) are considered for Nursing Facility Level of Care (NF LOC) eligibility:

1. BATHING: The ability to take a full body bath, shower, or bed bath, including transferring in and out of tub or shower and cleansing each part of the lower and upper body, including hair. Bathing may occur on a less than daily basis. Washing the back only is not included when determining whether the client has a limitation;
2. DRESSING: The ability to put on and remove clothing as needed from upper and lower body. This includes the ability to put on or remove physician ordered prosthetic/orthotic devices, braces, and compression stockings. This does not include laying out clothing, choosing weather-appropriate clothing, or tying shoelaces;
3. EATING: The ability to get food and drink from the dish/cup to the mouth, to use adaptive feeding devices without assistance, or to eat without constant supervision due to difficulties with swallowing or choking. This includes the intake of nourishment by other means (for example, gastrostomy, jejunostomy, or nasogastric tube, or intravenously with total parenteral nutrition). This does not include meal preparation, cooking, serving, cutting food, or opening containers;

4. MOBILITY/LOCOMOTION: The ability to ambulate or move between locations on the same level indoors with or without the assist of a mobility device. This includes devices such as a walker, cane, wheelchair, or crutches. If a wheelchair is the primary mode of mobility, the ability to be self-sufficient once in the wheelchair;
5. PERSONAL HYGIENE: The ability to complete at least two of the following tasks: comb/brush hair, perform oral hygiene, shave, wash and dry face and hands. This excludes baths, showers, applying make-up, and styling hair;
6. TOILETING: The ability to meet toileting needs by transferring on or off toilet, commode, or bedpan; use urinal; cleansing oneself after toilet use or incontinent episode; managing ostomy or catheter appliances; managing bowel flushes; completing a bowel program; or changing incontinence products and adjusting clothing; and
7. TRANSFERRING: The ability to move between surfaces including to and from the bed, chair, and wheelchair. Additionally, this includes the ability to move from a sitting to a standing position, and vice versa. This excludes transfers to and from the toilet, bath/shower, in and out of a vehicle, or in and out of non-standard seating (for example, chair height too low or too high).

12-003.01B Risk Factors: Risk factors must cause significant impact to the client's life and functional capacity, and must require administration of a significant intervention in a timely manner. Risk factors to be considered are:

1. Documented report of abuse and neglect in the past 12 months. This includes self-neglect;
2. Socially inappropriate behavior: The client exhibits a recurring behavior that is deviant or disruptive. Behaviors which are inappropriate are: wandering, inappropriate sexual behavior, assaultive behavior, and resistance to physical care. This also includes behaviors which stem from "thought impairment" such as hallucination, delusion, or suicidal ideation not related to a severe and persistent mental illness;
3. Communication: The client is unable to communicate information in a manner that is understandable and is unable to understand information conveyed. Information may be provided by any means (for example, verbally, in writing, sign language, message board). Exception: The client's inability to communicate due to a language barrier will not be considered to be a limitation;
4. Continence: The client is incontinent (that is, unable to control his or her body to empty the bladder and bowel) and unable to self-manage needs. This does not include accidents occurring less than daily;
5. Falls: The client has a history of at least two falls in the past six months which resulted in injury requiring physician treatment or hospitalization.
6. Housing: The client does not reside in safe, accessible, adequate housing;
7. Nutrition concerns: The client has a history (within the last twelve months) of recurring or persistent dehydration, malnutrition, or non-compliance with physician-ordered special diet; and

8. Lack of informal support: The client has no network of friends/relatives/ neighbors/staff or non-waiver providers who are physically, mentally, and psychologically able and willing to provide any care or support.

12-003.01C Medical Treatments: Medical treatments are considered to be factors in Nursing Facility Level of Care (NF LOC) when a specific intervention is required to prevent a decline in health status. The treatment must be one which requires physical assistance of another person. The following qualify:

1. Dialysis, radiation, chemotherapy, infusion and transfusion therapy;
2. Intravenous Therapies: Physical assistance with daily or alternate-day scheduled intravenous administration of medication, nutrition, or hydration;
3. Medication monitoring/management: Daily physical assistance with medications due to one of the following reasons:
   a. Client is physically unable to access and take prescribed medications (for example, opening the container, swallowing pills, inserting suppositories, injections, or glucose testing);
   b. Client does not demonstrate the ability to take medications correctly (for example: unable to demonstrate understanding of the right time, right dose, right route, right frequency and does not take, or has taken incorrectly); or Client is taking medications incorrectly (for example not taking, taking incorrect dosage, taking too frequently); or
   c. Client is requiring assistance with administration of medication by a gastrostomy, jejunostomy, or nasogastric tube;
4. Ostomies and Catheters: Care of colostomy, jejunostomy, ileostomy, ureterostomy, nephrostomy, cystostomy, or indwelling catheter. Intermittent straight catheterization must be performed a minimum of two times daily;
5. Pressure Ulcer Prevention**:** Daily skin care, pressure relieving products, or turning and positioning program to prevent pressure ulcers for individuals who are immobile or have been identified at high risk of developing pressure ulcers as a result of a medical condition or functional disability;
6. Respiratory Services: Daily tracheostomy care, partial or full day ventilator usage; daily oral/nasopharyngeal, tracheostomy machine suctioning; daily oxygen use or daily nebulizer treatments. This may include Positive Airway Pressure (PAP) device, Continuous Positive Airway Pressure (C-PAP) device, or Bi-Level Positive Airway Pressure (Bi-PAP) device; or
7. Wound care: Daily to weekly scheduled, physician ordered, medical treatments for care of pressure or stasis ulcers, surgical wounds, burns, or open lesions.

12-003.01C1 Medical Interventions: To qualify as a functional limitation in the medical area, each treatment must be addressed by one or more of the following specific interventions to prevent a decline in the individual's health status:

1. Medical care such as hospital admission or ongoing monitoring by a physician;
2. Home health nursing services for treatment or observation; or
3. Ongoing or intermittent treatment or observation by another person who is specifically trained to address the client's identified need(s).

12-003.01D Cognitive Function: Determination of a limitation in cognitive functioning is based on a related diagnosis, results of cognitive testing, or a history of poor judgment which has caused the client harm or loss. A limitation in this category means that the person's ability to function safely in his/her daily routine is affected.

Cognitive limitations may exist in one or more of the following areas:

1. Memory: Ability to remember past and present events;
2. Orientation: Ability to correctly recognize person, place, and time; or
3. Judgment: Ability to solve problems or make decisions about tasks of daily living, such as financial management.

12-003.02 Level of Care (LOC) Determination for Children age 17 or Younger: To meet Nursing Facility Level of Care (NF LOC) eligibility, a child must have assessed limitations in the child Level of Care (LOC) categories as follows:

1. Children age 0-35 Months: To be eligible, the child must have needs related to a minimum of one defined Medical Condition or Treatment as listed in 471 NAC 12-003.02A1.
2. Children age 36 months through 17 years: Nursing Facility Level of Care (NF LOC) eligibility can be met in one of three ways:
   a. At least one medical condition and treatment need (see 471 NAC 12-003.02A1);
   b. Limitations in at least six Activities of Daily Living (ADL) (see 471 NAC 12-003.02A2); or
   c. Limitations in at least four Activities of Daily Living (ADL) (see 471 NAC 12-003.02A2) and at the presence of least three other considerations (see 471 NAC 12-003.02A3).

For purposes of this section, the age of the child is his or her age on the last day of the month in which the Level of Care (LOC) determination is made.

12-003.02A Level of Care Criteria: The client or his or her authorized representative must provide the Nursing Facility Level of Care (NF LOC) information which is obtained through in-person discussion and observation of the child; reports from parents/legal representative/informal caregivers; documentation from the child's Individualized Family Service Plan (IFSP) or Individual Education Plan (IEP); and current medical records. Children with disabilities meet Nursing Facility Level of Care (NF LOC) eligibility based on the assessment categories of Medical Conditions and Treatments, Activities of Daily Living (ADL), and Other Considerations.

12-003.02A1 Determination of Medical Conditions and Medical Treatments: To qualify with a limitation in this category, a child shall have a defined, documented medical condition or receipt of treatment, which satisfies the requirements of both 471 NAC 12-003.02A1a and 12-003.02A1b.

12-003.02A1a Defined Medical Treatment and Medical Conditions: The following medical conditions and treatments are considered in determining Nursing Facility Level of Care (NF LOC) eligibility.

12-003.02A1a(i) Defined Medical Treatments:

1. Open pressure ulcer(s); or dressing changes to a wound that requires aseptic (sterile) technique;
2. Peritoneal dialysis at home;
3. Daily ventilator use. This includes Positive Airway Pressure (PAP) device, Continuous Positive Airway Pressure (C-PAP) device, or Bi-level Positive Airway Pressure (Bi-PAP) device;
4. Nasopharyngeal, tracheostomy or throat suctioning with machine suctioning to maintain patency of the airway;
5. Daily continuous oxygen with oximetry monitoring;
6. Intravenous (IV) medication(s) or IV fluids on at least an alternate-day schedule. This does not include routine flushes;
7. Tube feedings to assure at least minimum daily nutritional requirements. To qualify, 50% or more of caloric intake must be received via tube feeding. Tube feeding may also be used to administer medications that are not available or tolerated through another route. This does not include water nor fluids for hydration;
8. Daily bladder catheterization. This does not include set up, opening packages, clean up, prompting, cueing, or supervision;
9. Weekly routine IV coagulation factor medication, packed red blood cells/platelets, or enzyme infusion;
10. Antineoplastic therapy which includes oral or IV chemotherapy or radiation; and
11. Chronic pain management program with daily routine narcotic analgesics.

12-003.02A1a(ii) Defined Medical Conditions:

1. Epilepsy, including one of the following:
   a. Convulsive epilepsy with generalized tonic-clonic seizures that occur monthly for at least three months despite compliance with prescribed treatment; or
   b. Non-convulsive epilepsy with dyscognitive seizures or absence seizures that occur weekly for at least three months despite compliance with prescribed treatment.
2. A fluctuating, inconsistent medical condition that has required the child to receive hospitalization related to a single medical condition:
   a. Three or more times in the past 12 months; or
   b. For at least 30 days, if the child is less than 12 months old; and
3. A condition which a licensed medical provider has documented as terminal or would be considered terminal in the absence of active treatment.

12-003.02A1b Additional Criteria for Medical Conditions and Treatments: In addition to having a medical condition and treatment identified in 471 NAC 12-003.02A1a, the present medical condition and treatment must:

1. Impact the child's functioning and independence on a daily basis; and
2. Requires physical assistance of another person:
   a. To prevent a decline in health status; or

b. When the child is physically or cognitively unable to self-perform the medically necessary treatments.

Note: For children ages 36 months through 17 years, documentation of the daily effect of a defined medical condition or treatment on the child's functioning and independence is required.

12-003.02A2 Activities of Daily Living (ADL) for Children Age 36 months through 17 years: Information about limitations in Activities in Daily Living (ADL) is obtained from observation of the child in the home setting, reports from parents/guardians/caregivers, current medical records, and school records. Activities in Daily Living (ADL) are considered a limitation when the child, due to his or her physical disabilities, requires physical assistance from another person on a daily basis to complete the tasks associated with each Activities in Daily Living (ADL) defined in this section. For the purposes of this section (471 NAC 12-003.02A2), the term "ability" shall be interpreted to include the physical ability, cognitive ability and endurance necessary to complete identified activities. Verbal cues and guidance do not factor into the client's ability to complete identified activities. The following Activities of Daily Living (ADL) are considered for Nursing Facility Level of Care (NF LOC) eligibility:

1. BATHING: The ability to take a full-body bath, shower, or bed bath, including transferring in and out of the tub or shower, and cleansing each part of the upper and lower body. Washing the back or hair is not included when determining whether the client has a limitation. Bathing may occur on a less than daily basis. The following age based restrictions apply:
   i. If the child is 60 months or older and requires the physical presence of caregiver in the bath/shower area, a bathing limitation is present; and
   ii. If the child is younger than 48 months of age and requires the physical assistance of another at all times, but is physically able to participate, a bathing limitation is not present;
2. DRESSING: The ability to put on and remove clothing from upper and lower body. This includes the ability to put on or remove physician ordered prosthetic/orthotic devices, braces and compression stockings. This does not include laying out clothing, snaps, fasteners or tying shoelaces;
3. EATING: The ability to get food and drink from the dish/cup to the mouth or to load utensils, to use adaptive feeding devices without assistance, or to eat without constant supervision due to difficulties with swallowing or choking. This includes the intake of nourishment by other means (for example, gastrostomy, jejunostomy, or nasogastric tube, or intravenously with total parenteral nutrition). This does not include meal preparation, cooking, serving, cutting food, or opening containers. If the child is 60 months or older and needs constant supervision due to documented incidents of choking, an eating limitation is present;
4. MOBILITY/LOCOMOTION: The ability to ambulate or move between locations on the same level indoors with or without the assist of a mobility device. This includes devices such as a walker, cane, wheelchair or two crutches. If a wheelchair is the primary mode of mobility, the ability to be self-sufficient once in the wheelchair;

5. PERSONAL HYGIENE (Grooming): The ability to complete at least two of the following tasks: comb/brush hair, brush teeth, shave, wash and dry face and hands. This excludes baths, showers, applying make-up, styling hair, and flossing teeth. If the child is younger than 48 months of age and requires the help of another to complete a task, but the child is physically able to participate, a personal hygiene limitation is not present;
6. TOILETING: The ability to move on and off the toilet or commode, use the toilet, commode, bedpan or urinal, manage ostomy or catheter appliances, manage bowel flushes/enemas or needs physical assistance to change incontinence products throughout the day. This does not include occasional accidents or to adjust clothing. If the child is younger than 60 months of age and usually continent, but needs physical assistance for all parts of the task, a toileting limitation is not present; and
7. TRANSFERRING: The ability to move from one surface to another throughout the day including in and out of bed/crib, chair, wheelchair, and from the floor. Additionally, this includes the ability to move from a sitting to a standing position, and vice versa. This excludes transfers to and from the toilet, bathing area, high stools/chairs, and in and out of a vehicle.

12-003.02A3 Other Considerations for Children Age 36 Months through 17 Years:

1. Vision: The child has a documented visual impairment that is defined as a visual acuity of 20/200 or less in the better eye with the use of a correcting lens. When the child is not able to participate in testing using the Snellen or comparable methodology, documentation of an alternate method that demonstrates visual acuity is required;
2. Hearing: The child has a documented hearing impairment that is defined as the inability to hear at an average hearing threshold of 1000, 2000, 3000 and 4000 hertz (Hz) with the high fence set at an average of 65 decibels (dB) or higher in the better ear;
3. Communication: The child is not able to communicate his or her needs by any means. This includes speaking, writing, sign language, or use of a communication device. This does not include speaking a language other than English; and
4. Behavior (applies only to age 60 months or older): The child requires interventions based on a documented behavior management program developed and monitored by a psychiatrist, psychologist, mental health practitioner, or school counselor.

12-003.03 Persons Eligible: To be eligible for a Level of Care (LOC) determination, a person must meet each of the following conditions:

1. The person must be determined to be eligible for Medicaid, or under consideration for Medicaid eligibility;
2. The person must be requesting Medicaid funding to cover Nursing Facility (NF) services;
3. The person must not require a Preadmission Screening and Resident Review (PASRR) Level II screen; and
4. The person must be a Nursing Facility (NF) resident or considering Nursing Facility (NF) admission as evidenced by one of the following circumstances:

a. The person is an emergency room patient or has been admitted as a hospital inpatient and has a discharge plan that indicates admission to a Nursing Facility (NF);
b. The person lives in any less-restrictive living arrangement in the community and has applied for Nursing Facility (NF) admission;
c. The person has entered a Nursing Facility (NF) on a short-term basis for rehabilitative or convalescent care and is a Medicaid recipient; or
d. The person is a private pay Nursing Facility (NF) resident who has applied for Medicaid.

12-003.03A Special Circumstances Not Evaluated/Screened: Level of Care (LOC) will not be evaluated/reevaluated for Medicaid clients who:

1. Have previously been determined to meet Nursing Facility Level of Care (NF LOC) and return to the same Nursing Facility (NF) after discharge to a hospital, other Nursing Facility (NF), or swing bed. This exception does not apply for clients who have previously been discharged to an alternative level of care, or to the community;
2. Are Medicaid-eligible clients who admit to the Nursing Facility (NF) under hospice care;
3. Are Nursing Facility (NF) residents who elect hospice upon becoming Medicaid eligible;
4. Are receiving Nursing Facility (NF) care which is currently being paid by Medicare Level of Care (LOC) evaluation referral must be completed after Medicare coverage has ended);
5. Direct transfer from one Nursing Facility (NF) to another Nursing Facility (NF);
6. Have a Preadmission Screening and Resident Review (PASRR) Level II Level of Care (LOC) determination;
7. Are currently, or were previously eligible the month prior to Nursing Facility (NF) admission, for the Aged and Disabled Waiver program through the Department. (These persons have already been determined Nursing Facility Level of Care (NF LOC) so additional evaluation is not needed.);
8. Are admitted to a special needs Nursing Facility (NF) unit (refer to 471 NAC 12-014); or
9. Are currently eligible for the Program of All-inclusive Care for the Elderly (PACE) through the Department (These persons have already been determined to meet Nursing Facility Level of Care [NF LOC] so additional evaluation is not needed).

12-003.03B Evaluation Format: Evaluations will be conducted through the use of common evaluation tools. The evaluation tools reflect each area of Nursing Facility Level of Care (NF LOC) criteria (see 471 NAC 12-003.01), the amount of assistance required and the complexity of the care.

12-003.03C Referral

12-003.03C1 Minimum Referral Information: The following is the minimum information required to process a referral for Level of Care (LOC) determination:

1. The name, position and telephone number of the person making the referral;
2. The name of the Nursing Facility (NF) involved, if different than the referral source;
3. The name, date of birth, and social security number of the person to be evaluated; and
4. The date and time the referral is being made.

12-003.03C2 Receiving Referrals: When Medicaid receives a referral to evaluate an applicant for admission to a Nursing Facility (NF), they will begin to collect the information outlined in the evaluation tool. Information may be collected either in person or through telephone interviews. Based on the information gathered through the evaluation, Medicaid determines whether the applicant meets Nursing Facility Level of Care (NF LOC).

12-003.03C3 Applicable Time Frames: A referral will only be accepted if it is verified by Medicaid that an application has been received and is under consideration or if an individual is determined eligible for Medicaid. The Level of Care (LOC) evaluator shall complete a Level of Care (LOC) evaluation within three business days. If the evaluation is not completed, the applicant for admission shall be deemed to be appropriate for admission until a Level of Care (LOC) determination is completed and any required notice is given.

12-003.03C3a Retroactive Medicaid Level of Care (LOC) Determination: If a current Nursing Facility (NF) resident applies for Medicaid without informing the Nursing Facility (NF) and a Level of Care (LOC) referral is not completed during the Medicaid eligibility consideration period, the Nursing Facility (NF) must make an immediate referral to Medicaid when information is received that Medicaid has been approved. Medicaid shall perform an evaluation within 48 hours. If the following conditions are met, Medicaid coverage will be retroactive to the date of Medicaid eligibility:

1. The Nursing Facility (NF) has in place a process to inform private pay clients and their families that the Nursing Facility (NF) must be informed when a Medicaid application is made;
2. The Nursing Facility (NF) makes a referral to Medicaid immediately upon receipt of information about the opening of the Medicaid case. At the time of this referral, the Nursing Facility (NF) shall provide information on the date and means by which information about Medicaid eligibility was obtained; and
3. The resident meets the Nursing Facility Level of Care (NF LOC) criteria.

12-003.03C3b Level of Care (LOC) Referral 14-Day Post-Medicaid Determination: A Level of Care (LOC) approval determination will be effective as of the date of Medicaid eligibility if the referral is completed by the 14th calendar day following the Medicaid eligibility determination date.

12-003.03C3c Medical Records Level of Care (LOC) Determination: A Level of Care (LOC) referral will also be accepted and a medical records-based Level of Care (LOC) determination (i.e. review of medical documentation to substantiate Nursing Facility Level of Care [NF LOC] as defined in Section 12-003.01) will be completed if Medicaid eligibility is not approved until after the recipient dies or is discharged from the facility.

To qualify, the referral must be completed within 14 days of the Medicaid eligibility determination date, and the recipient must meet Level of Care (LOC) criteria. If the required conditions are met, the Level of Care (LOC) determination will be effective to the date of Medicaid eligibility.

12-003.03C3d Program of All-inclusive Care for the Elderly (PACE) Level of Care (LOC) Determination: A Program of All-inclusive Care for the Elderly (PACE) Level Care (LOC) determination may be used to substantiate Nursing Facility Level of Care (NF LOC) in the following cases:

1. A Program of All-inclusive Care for the Elderly (PACE) recipient immediately admits to (or already resides in) a Nursing Facility (NF) following their dis-enrollment from the Program of All-inclusive Care for the Elderly (PACE); or
2. A Program of All-inclusive Care for the Elderly (PACE) recipient admits to a Nursing Facility (NF) within 30 days of dis-enrollment from the Program of All-inclusive Care for the Elderly (PACE).

A Level of Care (LOC) determination will be required in all other cases for Nursing Facility (NF) admission.

12-003.04D Outcomes of the Evaluation:

12-003.04D1 Nursing Facility Level of Care (NF LOC) Met: If the Level of Care (LOC) evaluator determines that the applicant meets Nursing Facility Level of Care (NF LOC) criteria and the client chooses to receive Nursing Facility (NF) services, the Level of Care (LOC) evaluator makes appropriate notifications (see 471 NAC 12-003.04E1).

12-003.04D2 Nursing Facility Level of Care (NF LOC) Not Met: If the Level of Care (LOC) evaluator determines that the applicant does not meet Nursing Facility Level of Care (NF LOC), notification of the determination is issued to the applicant and the facility, applicant, and the Managed Care Organization (see 471 NAC 12-003.04E1). Persons who are found to be ineligible for Medicaid reimbursement for Nursing Facility (NF) service will be sent a notice of denial by the Level of Care (LOC) evaluator.

12-003.04D3 Possible Options: Medicaid payment for Nursing Facility (NF) services will only be available to those clients who are determined to require Nursing Facility Level of Care (NF LOC). They will have the option of entering a Nursing Facility (NF) or exploring home and community-based care services.

If the evaluation determines that there is a need for post-hospitalization rehabilitative or convalescent care, the Level of Care (LOC) evaluator may indicate that short-term or time-limited Nursing Facility (NF) care is medically necessary. Prior to the end of the short term stay, the Nursing Facility (NF) must contact Medicaid in order to review the client's condition and determine future Nursing Facility Level of Care (NF LOC).

12-003.04E Notices and Appeals

12-003.04E1 Level of Care (LOC) Determination Notification: Medicaid staff send notification to each client/family/applicable parties, to inform the client of the level of Care (LOC) decision.

Nursing Facility (NF) residents with Medicaid funding, who no longer meet the criteria for Nursing Facility Level of Care (NF LOC), must be allowed to remain in the facility up to 30 days from the date of the notice.

12-003.04E2 Appeals: The client or his or her authorized representative may appeal any action or inaction of the Department by following standard Medicaid appeal procedures as defined in 465 NAC 6-000.

If an appeal is held following denial of Nursing Facility (NF) services based on not meeting Nursing Facility Level of Care (NF LOC) criteria and the action is upheld, Medicaid shall refer the person to appropriate services.

~~12-003 Client Classification for Nursing Facility Services~~

~~12-003.01 Definition: Services furnished under physician orders and provided in facilities meeting CMS and HHS F&S definitions of a nursing facility, and which require the skills provided by or under the direct supervision of professional or technical personnel as defined in 42 CFR 483, Subpart B.~~

~~12-003.02 Nursing Facility Level of Care Criteria: HHS F&S applies the following criteria to determine the appropriateness of services on admission and at each subsequent review:~~

~~Services coordinators (HHS staff or contractors) collect information in the following assessment categories:~~

1. ~~Activities of daily living (ADL) -~~
   a. ~~Bathing: The ability to get to the bathing area and cleanse all parts of the body and the hair to maintain proper hygiene and prevent body odor, including tub, shower, and/or sponge bath.~~
   b. ~~Continence: The control of one's body to empty the bladder and/or bowel on time; the ability to change incontinence pads/briefs, cleansing, and disposing of soiled articles; ability to manage ostomy equipment; ability to self-catheterize.~~
   c. ~~Dressing/Grooming: The ability to put on and remove clothing as needed from both upper and lower body; the ability to do routine daily personal hygiene (combing hair, brushing teeth, caring for dentures, washing face and hands, and shaving).~~
   d. ~~Eating: The ability to take nourishment. This may include the act of getting food from the plate to the mouth, and does not include meal preparation.~~
   e. ~~Mobility: The ability to move from place to place indoors or outside.~~
   f. ~~Toileting: The ability to get to and from the toilet, commode, bedpan, or urinal, including transfer to and from the toilet, management of clothing, and cleansing.~~
   g. ~~Transferring: The ability to move from one place to another, including bed to chair and back, and into and out of a vehicle. (It does not include toilet transfer.)~~
2. ~~Risk Factors -~~
   a. ~~Behavior: The ability to act on one's own behalf, including the interest or motivation to eat, take medications, care for one's self, safeguard personal safety, participate in social situations, and relate to others in a socially-appropriate manner.~~
   b. ~~Frailty: The ability to function independently without the presence of a support person, including good judgment about abilities and combinations of health factors to safeguard well-being and avoid inappropriate safety risk.~~
   c. ~~Safety: The availability of adequate housing, including the need for home modification or adaptive equipment to assure safety and accessibility; the existence of a formal and/or informal support system; and/or freedom from abuse or neglect.~~

~~3. Medical Treatment or Observation~~

~~a. A medical condition is present which requires observation and assessment to assure evaluation of the individual's need for treatment modification or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self-observe and/or evaluate the need to contact skilled medical professionals; or~~

~~b. Due to the complexity created by multiple, interrelated medical conditions, the potential for the individual's medical instability is high or exists; or~~

~~c. The individual requires at least one ongoing medical/nursing service. The following is a non-inclusive list of such services which may, but not necessarily, indicate need for medical or nursing supervision or care:~~

~~(1) Application of aseptic dressing;~~
~~(2) Routine catheter care;~~
~~(3) Respiratory therapy;~~
~~(4) Supervision for adequate nutrition and hydration due to clinical evidence of malnourishment or dehydration or due to a recent history of weight loss or inadequate hydration which, if unsupervised, would be expected to result in malnourishment or dehydration;~~
~~(5) Therapeutic exercise and positioning;~~
~~(6) Routine colostomy or ileostomy care or management of neurogenic bowel and bladder;~~
~~(7) Use of physical (side rails, poseys, locked wards) and/or chemical restraints;~~
~~(8) Routine skin care to prevent pressure ulcers for individuals who are immobile;~~
~~(9) Care of small, uncomplicated pressure ulcers and local skin rashes;~~
~~(10) Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;~~
~~(11) Chemotherapy;~~
~~(12) Radiation;~~
~~(13) Dialysis;~~
~~(14) Suctioning;~~
~~(15) Tracheostomy care;~~
~~(16) Infusion therapy;~~
~~(17) Oxygen;~~
~~(18) Open lesions other than stasis or pressure sores (e.g., cuts);~~
~~(19) Wound care or treatment (e.g., pressure ulcer care, surgical wound);~~
~~(20) Intravenous medications;~~
~~(21) Transfusions;~~
~~(22) Medication monitoring; and/or~~
~~(23) Other special treatment or procedure.~~

~~4. Cognition~~

~~a. Memory: Ability to remember past and present events; does not need cueing;~~
~~b. Orientation: Fully oriented to person, place, and time.~~
~~c. Communication: Ability to communicate information in an intelligible manner, and the ability to understand information conveyed.~~
~~d. Judgment: Ability to solve problems well and make appropriate decisions.~~

~~The services coordinator may administer a standard mini-mental test, as appropriate, to further identify memory, orientation, and communication limitations. Additional exploration of judgment may also be necessary.~~

~~12-003.02A Determining NF Level of Care: Services coordinators collect the above information on each individual seeking NF or waiver services to determine the functional abilities and care needs of that individual. Information may be gathered from a variety of sources (e.g., the individual, family, care providers, physicians, facility staff, case files, medical charts), using observation, documentation review, and/or interview until sufficient information is obtained to determine the individual's current functioning in each area.~~

~~Persons who require assistance, supervision, or care in at least one of the following four categories meet the level of care criteria for Nursing Facility or Aged and Disabled Home and Community-based Waiver services:~~

1. ~~Limitations in three or more Activities of Daily Living (ADL) AND Medical treatment or observation.~~
2. ~~Limitations in three or more ADLs AND one or more Risk factors.~~
3. ~~Limitations in three or more ADLs AND one or more Cognition factors.~~
4. ~~Limitations in one or more ADLs AND one or more Cognition AND one or more Risk factors.~~

~~If the potential client does not meet the NF level of care criteria, the services coordinator shall inform the referral source of this decision and provide notice to the potential client/guardian, if that contact has been made. The services coordinator shall also provide appropriate information and referral. Notices to clients must contain -~~

1. ~~A clear statement of the action to be taken;~~
2. ~~A clear statement of the reason for the action;~~
3. ~~A specific policy reference which supports such action; and~~
4. ~~A complete statement of the client's right to appeal.~~

~~12-003.02B PASP Determination of Nursing Facility Level of Care: In determining eligibility for nursing facility services for an individual subject to the PASP process (per criteria in 471 NAC 12-003.02), the individual must meet NF Level of Care Criteria, and one criterion from Section A and one criterion from Section B.~~

~~Section A~~

~~A.1. Nursing need are primary and may include treatment and monitoring of the individual's medical needs, a protected structured environment, assistance with ADLs, nursing supervision, and monitoring to avoid further deterioration or complications.~~
~~A.2. Nursing needs outweigh the individual's capacity for living in a less restrictive setting and require technical or professional nursing supervision on a 24-hour basis.~~

~~Section B~~

~~B.1. Mental health needs do not require specialized services but may require mental health services as part of the overall plan of care, to include but not limited to services, such as medication monitoring, counseling and therapy, consultations with a psychiatrist, participation in activities.~~
~~B.2. Mental retardation/related condition needs to not require specialized services but may require rehabilitative services such as Physical Therapy, Occupational Therapy, Speech, social/recreational activities.~~

~~12-003.03 Mental Retardation/Related Conditions (MR/RC) Services in an NF: NF services may be provided to persons having a diagnosis of mental retardation or a related condition under the following conditions:~~

1. ~~When medical conditions meeting the NF level of care (see 471 NAC 12-003.02) are the primary need of the client; and~~
2. ~~Documentation of previous services and an assessment within the last year have determined that the individual's needs can adequately be met within the NF level of care; and~~
3. ~~The evaluation of appropriateness and adequacy of services is based on the information contained in Form HHS-OBRA9, "Summary of Findings" (see 471-000-231) with consideration of and incorporation of PASP recommendations in the client's comprehensive plan of care.~~

~~12-003.04 Mental Health (MH) Services in an NF: NF services may be provided to persons having a diagnosis of serious mental illness under the following conditions:~~

1. ~~When medical conditions meeting the NF level of care (see 471 NAC 12-003.02) are the primary need of the client; and~~
2. ~~Documentation of previous services and an assessment within the last year have determined that the individual's mental health needs can adequately be met within the NF level of care; and~~
3. ~~The evaluation of appropriateness and adequacy of services is based on the information contained in Form HHS-OBRA9, "Summary of Findings" (see 471-000-231) with consideration of and incorporation of PASP recommendations in the client's comprehensive plan of care.~~

12-004 Preadmission Screening Process (PASP): When an individual requests admission to or continuous residence in a Medicaid-certified bed in a nursing facility, the facility shall implement the Preadmission Screening Process (PASP) as defined in this chapter. An individual who has an indication or diagnosis of mental illness, mental retardation or a related condition, or a dual diagnosis may be admitted to a nursing facility or continue to reside in a nursing facility only when the individual is determined to be appropriate for nursing facility services through the PASP.

The PASP provides the following to an individual with a diagnosis or indication of mental illness, mental retardation or a related condition, or a dual diagnosis:

1. A determination whether the individual has mental illness, mental retardation or a related condition, or a dual diagnosis;
2. A determination whether the level of services provided by a nursing facility is appropriate to meet the individual's needs; and
3. A recommendation for services that addresses the individual's need(s) in a nursing facility or in an alternative placement (without regard to the availability of services).

12-004.01 Purpose of the PASP: The purpose of the PASP is to -

1. Determine the appropriateness of nursing facility care for persons with mental illness, mental retardation or a related condition, or a dual diagnosis;
2. Prevent the placement of individuals with mental illness, mental retardation or a related condition, or a dual diagnosis in nursing facilities unless their medical needs clearly indicate that they require the level of care provided by a nursing facility;
3. Create a linkage between the health care industry and the mental health and developmental disability systems;
4. Comply with state and federal requirements mandating an evaluation process that facilitates the nursing facility's responsibility to provide services and activities to attain and maintain the highest practical physical, mental, and psychosocial well-being of each resident; and
5. Assist with the placement of persons found inappropriate for nursing facility care into more appropriate, least restrictive services.

12-004.02 Level I Evaluation:

1. A Preadmission Screening Process (PASP) for -
   a. All persons who have requested a Medicaid certified NF bed and who have been determined by the HHS/contractor to have mental illness (MI) and/or mental retardation (MR) or a related condition (RC) as defined under 471 NAC 12-004.05.
   b. Any request for a first time admission or readmission to a Medicaid certified NF for a resident who has been treated in an inpatient psychiatric setting or equally intensive service, e.g., crisis unit, and the HHS/contractor has determined that the individual qualifies for such preadmission review per criteria provided under 471 NAC 12-004.05.

2. The Status Change Process is required for all NF residents who -
   a. Have never been evaluated through the PASP process but have been determined to exhibit signs, symptoms, and/or behaviors suggesting the presence of a diagnosis of MI and/or MR/RC (as defined under 471 NAC 12-001.04.
   b. Have demonstrated an increase in symptoms and/or behaviors to the extent that there is a change in mental health and/or mental retardation treatment needs.
   c. Have demonstrated a significant physical status improvement such that s/he is more likely to respond to special treatment for that condition or s/he might be considered appropriate for a less restrictive placement alternative.
   d. Have required inpatient psychiatric treatment. A Level II status change is required prior to the individual's readmission to the facility.
   e. Have been approved for NF stay for a short term period and the individual's stay is expected to exceed the approved time frame.

12-004.03 Exempted Hospital Discharge: Federal regulations offer an exemption from the Level II PASP process for individuals with mental illness and/or mental retardation/related conditions who are being discharged from the hospital to the NF for a NF stay which is expected not to exceed thirty calendar days. Qualifying criteria for the Exempted Hospital Discharge exemption are as follows -

1. The individual meets criteria for serious mental illness and/or mental retardation or a related condition as described in 471 NAC 12-004.05.
2. The individual is being admitted to a nursing facility directly from a hospital after receiving acute inpatient medical care at the hospital (excluding inpatient psychiatric care);
3. The individual requires nursing facility services for the condition for which s/he received care; and
4. The individual's attending physician has certified on the hospital discharge orders or the nursing facility admission orders that admission to the NF facility is likely to require less than 30 days of nursing facility services. The hospital shall complete the HHS-OBRA1 (see 471-000-223) with a physician's signature to reflect a request for this type of approval.

The nursing facility shall ensure that the discharge orders or the admitting orders contain the physician's certification of this provision. The nursing facility shall send copies of Form HHS-OBRA 1, completed to indicate the exempted hospital discharge, to the HHS/contractor and, if the individual is Medicaid-eligible, to HHS F&S. The Level I evaluation portion of Form HHS-OBRA1 is not completed for an exempted hospital discharge.

Medicaid pays for nursing facility stays for Medicaid-eligible clients under the exempted hospital discharge provision only when the HHS-OBRA1, indicating the exempted hospital discharge, accompanies the prior authorization request.

12-004.03A Level I Evaluation: A Level I Screen is required for any individual who -

1. Is applying for first time admission to a Medicaid certified NF bed;
2. Was previously formally discharged from a NF and is applying for admission to the same or another Medicaid certified NF;
3. Is being admitted or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment (e.g., crisis unit);
4. Was evaluated through the PASP Level II process more than 90 days before admission to a Medicaid certified NF could be expedited;
5. Was screened as a Negative Level I but whose placement was delayed longer than 12 months from the previous Level I screen.
6. Was screened as a Negative Level I but whose behaviors and/or symptoms now suggest the presence of mental illness and/or mental retardation/related conditions as defined under 471 NAC 12-004.05.
7. Was approved under 471 NAC 12-004.07 as a short term categorical admission or an Exempted Hospital Discharge and whose stay is expected to extend beyond approved time frames.

12-004.03B Level I (Identification Screen) Outcomes: Forms HHS-OBRA1 and HHS-OBRA1a, as applicable, must be submitted to HHS/contractor prior to an individual's admission to a Medicaid certified NF bed and under those circumstances specified above. Outcomes are as follows:

1. Negative Screens - For ID screens which are clearly negative, the referral source must submit a copy of the HHS-OBRA1 to HHS Finance and Support Medicaid, and the HHS/Contractor. No verbal contact is required with the HHS/Contractor regarding that screen.
2. Questionable Screens - In cases where information suggests the possibility of a MI and/or MR/RC, the referral source must submit medical records information with the HHS-OBRA1 and HHS-OBRA1a, as applicable, to clarify the presence/absence of the suspected disorder. Examples of clarifying information include data specified under 471 NAC 12-004.08.
   When an individual's condition suggests that some but not all criteria are met to qualify as MI and/or MR/RC under the criteria provided in 471 NAC 12-004.05, the HHS/Contractor will exclude the individual from the PASP Level II process and will forward notification to the referral source indicating that any later status change suggesting full qualification for such a condition should be forwarded to the HHS/Contractor for consideration of Level II need.
3. Modified Level I Screens - In cases where the Level I review agent adds/modifies information presented on the Level I screen, changes and their rationale will be so noted on the protocol. A copy of the modified protocol will be forwarded to the Medicaid Division as well as to the referring facility by the Level I screening agency. The modified HHS-OBRA1 protocol must be maintained in the individual's permanent medical record.

4. Exempted Hospital Discharges and Categorical Determination (OBRA1a) - Requests for exemptions or categorical decisions must include supportive documentation. Both the Exempted Hospital Discharge provision and the categorical determination options allow the individual to be admitted to a nursing facility without requiring performance of an on-site Level II evaluation. The options are indicated on the OBRA1a and offer either short term approvals or categorical approvals based upon certain presenting circumstances. Short term options allow for only brief admission, whereby further contact must be made with the HHS/contractor to initiate re-screening through the Level I and arrangements for the Level II if the individual's stay is expected to exceed the approved time frame. Refer to 471 NAC 12-004.07 for an explanation of those determinations and applicable time frames.
5. Positive Level I Screen - The reviewing agent will request medical records information which sufficiently supports that the individual meets criteria for a PASP evaluation as indicated in 471 NAC 12-004.05A and B. If the individual is identified as potentially having MR/RC, the Level I review agency will additionally request information regarding whether the presence of MR has been clinically diagnosed through psychological testing.

12-004.04 Transfers: A nursing facility-to-nursing facility transfer does not require the completion of a new Form HHS-OBRA1 (see 471-000-223) or the completion of a new Level II PASP evaluation. The discharging facility must send a copy of the most recent Level I/II, as applicable, screening information to the admitting facility at the time of transfer.

The Level II determination applies to nursing facility services and is not facility-specific. The only exception is for a specialized nursing facility, and these determinations may not be transferred from one facility to another.

12-004.05 Identification Criteria

12-004.05A Identification Criteria For Individuals With Mental Illness: An individual is considered to have a serious mental illness and requires a Level II evaluation if the individual meets all three of the following three qualifiers:

1. Diagnosis Qualifier: The individual has a psychiatric diagnosis which, by accepted clinical standards, is determined to be a serious and persistent psychiatric condition, diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition or its revisions. The mental disorder must be characterized as likely to lead to a chronic disability but cannot be a primary psychiatric diagnosis of dementia or a related disorder. For the purpose of this definition, Alzheimer's and organic disorders are considered related disorders to dementia. If dementia or a related disorder co-exists with a serious and persistent mental illness which is not a dementia, the dementia or related disorder must be predominant and progressive to exempt the co-occurring psychiatric condition from this qualifier.

2. Disability/Level of Impairment Qualifier: Within the past six months, the psychiatric disorder has resulted in functional limitations in one or more of the following major life activities on a continuing or intermittent basis:
   a. Serious difficulty interacting appropriately and communicating effectively with other persons. Examples of such difficulty may include but are not limited to, possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation;
   b. Serious difficulty in sustaining focused attention for a sufficient period to complete tasks for which s/he should be medically capable. Examples of such difficulty may include but are not limited to concentration difficulties, inability to complete simple tasks within an established time period, frequent errors related to task completion, or need for assistance in completion of tasks; or
   c. Serious difficulty adapting to typical changes in circumstances. Examples of such difficulty may include but are not limited to agitation, exacerbated signs and symptoms of the psychiatric condition, withdrawal from the situation, or need for intervention by the mental health or judicial system.
3. Duration/Recent Treatment Qualifier: The treatment history indicates that the individual has experienced at least one of the following:
   a. Psychiatric treatment more intensive than outpatient care (e.g., partial hospitalization, psychiatric inpatient care, crisis unit placement) once within the past two years for a nursing facility resident or more than once in the past two years for a nursing facility applicant; or
   b. Within the last two years, due to the mental disorder, experienced a major episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. For the purpose of this definition, major episode of significant disruption may include an involuntary psychiatric hospitalization, suicidal attempts or gestures, 1:1 monitoring, and/or other issues which are safety-related or involved.
   c. Within the past two years, residence in a psychiatric hospital which required a period of hospitalization greater than that which is typically required for acute stabilization (e.g., inpatient psychiatric hospitalization extending beyond 30 days).

<u>12-004.05A1 Indicators</u>: In addition to the criteria listed in 471 NAC 12-004.05A, the following indicators may be considered evidence of a serious mental illness:

1. The individual has a recent history (within the last two years) of a serious mental illness;
2. There is presenting evidence of a serious mental illness which includes possible disturbances in orientation, affect, or mood, and the primary psychiatric condition is not dementia, Alzheimer's disease or a related disorder. "Primary" means that the symptoms of the dementia supersede symptoms of any co-occurring psychiatric condition; and
3. The individual has been prescribed a psychoactive medication on a regular basis, expressly for the indicators identified above.

12-004.05A2 Dementia, Alzheimer's Disease, or Related Disorder: An individual is considered not to require a PASP Level II psychiatric evaluation if dementia or a related disorder can be ranked as primary over any additional co-occurring psychiatric disorders, where present, and the dementing condition meets established clinical standards specified in the Diagnostic and Statistical Manual, Version IV. In circumstances of dementia which co-occurs with other physical conditions but is said to be the primary psychiatric disorder, the facility must make a reasonable effort as specified under 471 NAC 12-004.05A, diagnosis qualifier, to provide documentation to the HHS/contractor that the dementing condition is primary.

Note: If one of two psychiatric disorders is dementia, Alzheimer's disease, or a related disorder and the other psychiatric disorder is a serious mental illness, the Level II evaluation will be required if the facility cannot provide sufficient data to support a clear clinical ranking of primary dementia.

12-004.05B Identification Criteria For Individuals With Mental Retardation or a Related Condition/Developmental Disability: An individual is considered to have a mental retardation or a related condition and requires a Level II evaluation if the individual meets any of the following criteria:

1. Suspicion or diagnosis of Mental Retardation (MR): An individual is considered to have mental retardation if s/he has a level of mental retardation (mild, moderate, severe, profound) as described in the American Association on Mental Retardation's Manual or Classification in Mental Retardation (1983). Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period; and/or
2. Suspicion or presence of a Related Condition/Developmental Disability (RC): Related condition is defined as a severe, chronic disability whose condition is:
   a. Attributable to cerebral palsy or epilepsy; or any other condition, other than MI, found to be closely related to MR because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with MR and requires treatment or services similar to those required for such persons (i.e., autism);
   b. Manifested before the person reached age 22;
   c. Likely to continue indefinitely;
   d. Results in substantial functional limitations in three or more of the following areas of major life activity:
      (1) Self-care;
      (2) Understanding and use of language;
      (3) Learning;
      (4) Mobility;
      (5) Self-direction;
      (6) Capacity for independent living.

Note: In the absence of a known diagnosis of MR or a related condition, a suspicion (e.g., cognitive or adaptive limitations) or history of treatment by an agency serving individuals with such conditions should trigger the housing/receiving facility to contact the HHS/contractor for a determination of need for Level II evaluation under the PASP program.

12-004.06 Negative Screens: If a Medicaid-eligible client does not require a Level II evaluation and is admitted to the nursing facility, the facility shall -

1. Send a copy of Form HHS-OBRA1 (see 471-000-223) to the to HHS/contractor;
2. Send a copy of Form HHS-OBRA1 to the client's local office along with Form MC-9NF (see 471-000-203); and
3. Retain a copy of Form HHS-OBRA1 in the resident's permanent nursing facility record.

If a non-Medicaid-eligible individual does not require a Level II evaluation and is admitted to the nursing facility, the facility shall send a copy of Form HHS-OBRA1 to HHS/contractor and retain a copy in the resident's permanent nursing facility record.

12-004.06A Medicaid Payment: If a Medicaid-eligible client does not require a Level II evaluation and is admitted to the nursing facility, Medicaid payment for NF services can begin no earlier than the date the ID screen is completed.

12-004.07 Categorical Determinations and Exemptions: If the results of a Level I evaluation, based on current medical documentation, indicate that an individual has a diagnosis or an indication of mental illness, mental retardation or a related condition, and meets one of the following conditions, the individual qualifies for a "categorical determination" or an exempted hospital stay and does not require an on-site Level II evaluation prior to NF admission. Admission to the nursing facility for an individual qualifying under a categorical determination or Extended Hospital Stay may proceed only after approval is provided by HHS/contractor. Options include:

1. Categorical Emergency Seven Day - The individual is being admitted pending further assessment in an emergency situation requiring protective services for a period not to exceed seven calendar days. Before admission can occur, documentation or verbal description of emergency need must be provided to, and approval must be secured by, the HHS/contractor. Forms HHS-OBRA1 (see 471-000-223) and HHS-OBRA1a (see 471-000-226) must be submitted along with the above.
   If it is determined that the individual's stay in the NF will continue beyond the approved seven-day time frame, the receiving facility must contact HHS/contractor as soon as the determination is made that continued stay will be required and no later than the seventh calendar day following admission, in order to arrange an on-site Level II evaluation.
2. Categorical Respite 30 Day - The individual is being admitted to provide respite care for a period not to exceed 30 calendar days for in-home caregivers to whom the individual is expected to return. Before admission can occur, documentation supporting the need for respite services placement must be provided along with Forms HHS-OBRA1 and HHS-OBRA1a to HHS/contractor.
   If it is determined that the individual's stay in the NF will continue beyond the approved 30-day time frame, the receiving facility must contact HHS/contractor as soon as the determination is made that continued stay will be required and no later than the 30th calendar day following admission, in order to arrange an on-site Level II evaluation.

3. Categorical Progressed Dementia with MR/RC: The individual has mental retardation or a related condition along with a co-occurring diagnosis of progressed dementia, Alzheimer's disease or related disorder. Both of the following must also be present: The diagnosis of dementia, Alzheimer's disease or related disorder must be considered the primary diagnosis and the individual must be considered to be in the advanced stages of this condition and no longer able to meaningfully participate in or benefit from a program of specialized services. Before admission can occur, medical records information which supports that the individual qualifies under this criterion must be provided to HHS/contractor along with Forms HHS-OBRA1 and HHS-OBRA1a.
4. Categorical Serious Medical - The individual's medical condition renders him/her unable to benefit from a plan of specialized services and clearly meets criteria for NF care. Applicable conditions include: Coma, Ventilator Dependence, Brain Stem Injury, End-Stage Medical Condition. In order to qualify, medical records information which support that the individual qualifies under this criterion must be provided along with Forms HHS-OBRA1 (see 471-000-223) and HHS-OBRA1a (see 471-000-226) to HHS/contractor before the individual's admission can occur.
5. Exempted Hospital Discharge - Federal regulations also offer an exemption from the Level II PASP process for individuals with mental illness and/or mental retardation/related conditions who meet Exempted Hospital Discharge criteria discussed in 471 NAC 12-004.03.

12-004.07A Documentation of Categorical Determinations and Exempted Hospital Discharge: The facility shall send Forms HHS-OBRA1, HHS-OBRA1a, and documentation supporting the categorical determination or Exempted Hospital Discharge to HHS/contractor before admission for an individual with mental illness, mental retardation, or a relation condition may occur. Documentation requirements are provided under attendant criteria in 471 NAC 12-004.07 and may also include a current history and physical, physician's orders, discharge plan, etc., if required by HHS F&S or its contractor to verify the individual's mental or medical status.

12-004.07B Report: After approval of a Categorical Determination, the following will be issued to individuals listed in 471 NAC 12-004.07C by HHS/contractor: a notification letter (HHS-OBRA5) (see 471-000-227), Form HHS-OBRA1, and Form OBRA1a which -

1. Identifies the name of the clinician operating on behalf of HHS/contractor to approve the categorical determination;
2. The date of the categorical determination;
3. The basis for the determination;
4. Identifies any further PASP evaluation requirements; and
5. Identifies any additional nursing facility services recommendations needed by the individual during the stay covered by the categorical determination.

Note: Notification of approval under the Exempted Hospital Discharge provision will be forwarded to HHS F&S and the referring source along with Forms HHS-OBRA1, HHS-OBRA1A, and a notification letter (HHS-OBRA5) explaining provisions of the exemption.

12-004.07C Notice: Following the categorical determination, the HHS/contractor shall issue Form HHS-OBRA5 (see 471-000-227) prior to admission to -

1. The individual or his or her legal representative;
2. The referral source or discharging hospital;
3. The individual's physician;
4. The Department of Health and Human Services Finance and Support, Medicaid Division; and
5. Nursing facility if known.

12-004.07D Stay Beyond Specified Limits: If the individual with MI, MR, and/or RC qualified for a categorical determination or an Exempted Hospital Discharge which involved a time limited admission, HHS/contractor must be contacted if the stay is expected to exceed the approved time frame and no later than the conclusion of the approved time frame in order to arrange an on-site Level II evaluation. The facility shall coordinate such a contact through submission of an updated HHS-OBRA1 (see 471-000-223) to HHS/contractor. Other data elements specified under 471 NAC 12-004.08 are required either at the initial notification of continued stay or at the arrival of the on-site evaluator. The on-site Level II evaluation will be completed within nine business days of the request. Medicaid payment will not be allowed beyond the specified time limits if contact with HHS/contractor is not made prior to the conclusion of the time frame.

12-004.07E Medicaid Payment: If the documentation supports the categorical determination, Medicaid payment can begin no earlier than the date the Form HHS-OBRA1 is completed.

If the documentation does not support the categorical determination, a Level II evaluation must be initiated immediately. The nursing facility shall submit the information listed in 471 NAC 12-004.08 to HHS/contractor. Medicaid payment can begin no earlier than the date of the Level II determination.

12-004.08 Individuals Who Require a Level II Evaluation: Following the first time identification that an individual requires a Level II evaluation, Form HHS-OBRA5 (see 471-000-227) will be issued to the individual or his/her legal representative to notify the individual that s/he has an indication or diagnosis of MI and/or MR/RC and is being referred for a Level II evaluation. Form HHS-OBRA5 will be issued upon receipt of Form HHS-OBRA1 (see 471-000-223) and any required medical/social information HHS/contractor. The NF, hospital, or other party must collect data elements specified below this paragraph at the time of request for admission and prepare copies for the HHS/contractor's on-site assessor to obtain at the time of the evaluation. If HHS/contractor determines that portions or all such information is required to determine whether the individual has a condition warranting a Level II PASP evaluation, the referring source must forward such information to HHS/contractor by mail or facsimile so that a determination of Level II need can be made. If a determination of Level II need can be made without the provision of the information, the referring facility must collect the data requirements specified below and forward copies of such documents to the on-site Level II PASP evaluator. Information requests include:

1. Form HHS-OBRA8 (see 471-000-230) (signed Release of Information);
2. A Social History which contains current psychological information specified in the Guidelines for Social History found in 471-000-234. The Social History must be completed or countersigned by a social worker certified by the Department of Health and Human Services Regulation and Licensure;

3. One of the following:
   a. Form DM-5-LTC, “Long Term Care Evaluation” (see 471-000-222);
   b. Form “MDS2.0” (see 471-000-43);
   c. Form MC-75Q, “MDS2.0 Quarterly” (see 471-000-44); or
   d. Form MC9NF, “Prior Authorization for Nursing Facility Care" (see 471-000-203);
4. History and Physical examination or a copy of Form DM-5 “Physician’s Confidential Report” (see 471-000-221); and
5. Guardianship certification, if applicable.

The nursing facility retains a copy of Forms HHS-OBRA1 and HHS-OBRA8 in the individual's permanent nursing facility record.

12-004.08A Medicaid Payment: If a Medicaid-eligible client requires a Level II evaluation and is admitted to the nursing facility, Medicaid payment for NF services can begin no earlier than the date of the PASP final determination.

12-004.08B Admission to a Nebraska Facility From Another State: The nursing facility shall notify HHS/contractor of potential admissions and shall complete Forms HHS-OBRA1 (see 471-000-223) and HHS-OBRA1a (see 471-000-226), as applicable, prior to the individual's admission to a Nebraska Medicaid-certified NF. If the individual is determined by HHS/contractor to require a Level II evaluation, the Level II determination must be completed before the applicant may be transferred to the Nebraska facility. In circumstances where HHS/contractor is unable to arrange an on-site evaluation in the transferring individual's home state, the HHS/contractor shall request medical records information to make document-based determinations of NF need and need for specialized services. If unable to make a determination of NF need based upon Nebraska Medicaid nursing home level of care criteria, Medicaid coverage for NF services for the individual will be denied.

12-004.08C Admission of Nebraska Residents to Out-of-State Facilities: If an individual is transferring from the State of Nebraska to an out-of-state Medicaid-certified nursing facility, the preadmission process (including the Level II evaluation, if required) must be completed before the individual leaves the state.

12-004.09 Level II Evaluation: The Level II evaluation process determines -

1. Whether the individual has mental illness and/or mental retardation/related condition as defined by federal regulations and as specified under 471 NAC 12-004.05A and 12-004.05B, respectively.
2. Whether the level of services provided by a NF or another institutional placement is appropriate to meet the individual's needs; and
3. For applicants determined to require NF placement and for all evaluated NF residents, services which are required to meet the evaluated individual's needs, including mental health services which are of lesser intensity than specialized services and are the responsibility of the receiving/retaining facility and/or specialized services which are the responsibility of the State.

12-004.09A Returning From Receiving Specialized Services for Mental Illness: If an individual is returning to a nursing facility from receiving specialized services for mental illness, s/he requires a new Level I screen to determine further screening requirements. If the Level I screen indicates that the individual meets serious mental illness criteria as indicated in 471 NAC 12-004.05A, a Level II summary of findings report must be issued. The summary may be based upon a document-based review of the psychiatric facility's medical records, if an on-site Level II assessment was performed within the 90-day period and current documentation supports that the individual is sufficiently stable. An on-site evaluation is required if an on-site Level II has not been performed within the prior 90-day period or if the documentation does not sufficiently indicate adequate psychiatric stabilization.

12-004.09B Facility Action: For each individual who requires a Level II evaluation, the nursing facility, hospital, or other party shall obtain medical records information specified in 471 NAC 12-004.08. The referring source must forward the information to HHS/contractor by mail or facsimile so that a determination of Level II need can be made.

12-004.09C HHS-OBRA Action: HHS/contractor shall refer evaluations of individuals with psychiatric conditions to licensed mental health practitioners or registered nurses with psychiatric experience. Evaluations of individuals with mental retardation will be referred to QMRPs as defined under 471-000-233 and/or to licensed psychologists. Evaluations of individuals with both mental illness and mental retardation or related conditions will be referred to each evaluator discipline described above.

HHS/contractor shall send information identified in 471 NAC 12-004.08 as well as the completed evaluation components to HHS F&S for preadmission screening evaluations on a weekly basis and following the conclusion of the PASP evaluation/determination process.

12-004.09D HHS F&S Action: The Department of Health and Human Services Finance and Support Central Office, Medicaid Division shall maintain review data along with other appropriate medical screening documentation for that individual.

12-004.09E Mental Health Evaluator Action: For each individual with an indication or diagnosis of mental illness, the evaluator shall complete Form HHS-OBRA2, "Evaluation and Service Recommendation (see 471-000-224)," which contains medical, functional, and psychosocial information. The on-site evaluation and the final validation and summary report must be completed by the seventh business day of the referral for an evaluation by the Level I screening agency to the on-site evaluator. Following completion of the on-site evaluation, evaluative data will be reviewed and countersigned by a board-eligible or board-certified psychiatrist who will: validate whether the individual has a mental illness (as defined in 471 NAC 12-004.05A), summarize the individual' medical and social history, provide recommendations to meet the individual's service needs, and provide recommendations regarding the individual's placement needs.

12-004.09F Mental Retardation/Related Condition Evaluator Action: For each individual with an indication of mental retardation or a related condition, the evaluator will complete the on-site evaluation. The on-site evaluation and the final validation and summary report will be completed by the seventh business day of the referral for an evaluation by the Level I screening agency to the on-site evaluator. Intellectual testing and an adaptive behavior scale will be administered to establish a diagnosis if: testing performed within the past three years is not available; the individual is not currently or has not historically received services from a community-based provider; or the individual is not currently or was not historically placed in an ICF/MR.

Testing performed more than three years before may be used in lieu of newly administered testing if results are available and considered accurate. If contradictory information is present, psychological testing will be performed.

In addition, Form HHS-OBRA2 MR/RC (see 471-000-225) which contains medical, function, and psychosocial information will be completed by a QMRP. This protocol identifies the extent to which the individual's status compares with each of the following skill deficits typically associated with individuals with mental retardation or related conditions:

1. Ability to accomplish most personal needs;
2. Ability to understand simple commands;
3. Ability to communicate most needs and wants;
4. Ability to be employed at a productive wage level without systematic long term supervision or support;
5. Ability to learn new skills without aggressive and consistent training;
6. Ability to apply skills learned in a training situation to other settings without aggressive and consistent training;
7. Ability to demonstrate behavior appropriate to the time, situation, or place without direct supervision;
8. Demonstration of severe maladaptive behavior(s) which place the individual or others in jeopardy to health and safety; and
9. Ability or extreme difficulty in making decisions requiring informed consent; or
10. Other skill deficits or specialized training needs which necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills.

12-004.09G Adaptation to Culture, Language, and Ethnic Origin: HHS/contractor shall ensure that the Level II evaluation is adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.

12-004.09H Participation in the Level II Evaluation: The mental health and/or QMRP evaluator shall contact the retaining facility to coordinate the time and date of the on-site evaluation and to assure that the Form HHS-OBRA8 (see 471-000-230) has been or will be signed. If the individual has a legal representative, the facility shall notify the legal representative of the scheduled assessment time/date and invite him/her to participate. The family must likewise receive notification from the facility of the pending evaluation, if family is available and if the individual or his/her legal representative agrees to family participation.

12-004.09J Pre-Existing Data: Relevant evaluative data collected prior to the Level II evaluation may be used if the data is considered valid and accurate and it reflects the current functional status of the individual. To supplement existing data, the Mental Health Reviewer and/or QMRP shall gather additional information necessary to assess proper placement and treatment.

12-004.10 Stopping the Level II Evaluation: If, at any time during the Level II evaluation, it is found that the individual does not meet criteria for mental illness (471 NAC 12-004.05A) and/or mental retardation or a related condition (471 NAC 12-004.05B), the Level II evaluation shall be stopped and admission to the nursing facility can proceed according to standard procedures for admission. The HHS/contractor shall send written notification to -

1. The client or his/her legal representative;
2. The facility which initiated the Level II evaluation;
3. The Department of Health and Human Services Finance and Support Central Office, Medicaid Division; and
4. The individual's physician.

If the individual's status changes, later suggesting the presence of mental illness and/or mental retardation or a related condition, the Level I must be resubmitted to HHS/contractor as a status change.

12-004.11 Resident Review/Status Change (RR/SC): This is required for exempted hospital discharge and categorical determinations that exceed the approved time frame; and for significant change status (471 NAC 12-007.06D).

12-004.11A RR/SC for Exempted Hospital Discharges and Categorical Determination: If the individual with MR, MR, and/or RC qualified for a categorical determination or a convalescent exemption involving a time limited admission, HHS/contractor must be contacted if the stay is expected to exceed that time frame and no later than the conclusion of the approved time frame to arrange an on-site Level II evaluation. The facility shall coordinate the contact through submission of Form HHS-OBRA1 (see 471-000-223) to HHS/contractor. Procedures for the on-site evaluation shall occur as specified under 471 NAC 12-004.07 and 12-004.08.

12-004.11B RR/SC for Significant Change Status: If the individual meets the definition of significant change status (471 NAC 12-007.06D), HHS/contractor must be contacted to arrange an on-site Level II evaluation. The facility shall coordinate such a contact through submission of Form HHS-OBRA1 to HHS/contractor. Procedures for the on-site evaluation shall occur as specified under 471 NAC 12-004.08.

12-004.11C HHS/Contractor Action: HHS/contractor shall forward the notification of RR/SC assessment outcome to HHS F&S Medicaid Division on a monthly basis.

12-004.11D HHS F&S Action: The Department of Health and Human Services Finance and Support Medicaid Division shall maintain review outcome data along with other appropriate medical screening documentation for that individual.

12-004.11E Mental Health Evaluator Action: For each individual subject to the RR/SC, evaluator actions specified under 471 NAC 12-004.09E for PASP MI evaluations shall be completed.

12-004.11F Mental Retardation/Related Conditions Evaluator Action: For each individual subject to the RR/SC, evaluator actions specified under 471 NAC 12-004.09F for PASP MR/RC evaluations shall be completed.

12-004.12 Final Determination Criteria: HHS/contractor shall use the following criteria to make the final determination for each individual who requires a Level II evaluation.

12-004.12A Appropriate for NF Services: An individual with mental illness, mental retardation or a related condition, is considered appropriate for nursing facility services if it is determined through a Level II evaluation that -

1. Nursing needs are primary and may include treatment and monitoring of the individual's medical needs, a protective structured environment, assistance with ADL's, nursing supervision, and monitoring to avoid further deterioration or complications (see 471 NAC 12-002.02C);
2. Nursing needs outweigh the individual's capacity for living in a less restrictive setting and require technical or professional nursing supervision on a 24-hour basis;
3. Mental health needs do not require specialized services but may require mental health services as part of the overall plan of care, to include but not limited to services such as medication monitoring, counseling and therapy, consultations with a psychiatrist; or
4. Mental retardation/related condition needs do not require specialized services but may require MR/RC services as part of the overall plan of care, to include but not limited to services such as physical therapy, occupational therapy, speech, social/recreational activities, etc.

12-004.12B Inappropriate for NF Services: An individual with mental illness, mental retardation or a related condition, is considered inappropriate for nursing facility services if it is determined through a Level II evaluation that s/he does not require nursing facility services but does require -

1. Inpatient psychiatric treatment or equally intensive services;
2. Mental health, mental retardation or developmentally disabled services at a level which is defined in 471 NAC 12-001.04 as specialized services; or
3. Alternative services.

12-004.12C Physician Letter: HHS/contractor shall notify the individual's physician by letter if the individual is inappropriate for NF services before issuing Form HHS-OBRA5 (see 471-000-227).

12-004.13 Notification of Final Determination: HHS/contractor shall make a final determination after reviewing the information obtained from the Level II evaluation and shall prepare an evaluative report of such findings. This report, HHS-OBRA9 (see 471-000-231), includes the following data elements -

1. Identification of the name and professional title of person(s) who performed the evaluation and the dates on which each portion evaluation was administered;
2. A summary of the medical and social history, including the positive traits or developmental strengths and weaknesses or developmental needs of the evaluated individual;
3. If NF services are recommended, identification of the services which are required to meet the evaluated individual's needs, including mental health services which are of lesser intensity than specialized services and are be the responsibility of the receiving/retaining facility;
4. If specialized services are recommended, identification of the mental health/mental retardation services required to meet the individual's needs; and
5. The basis for the report's conclusions.

Summary reports will be accompanied by a notification letter which defines placement and service determinations and provides appeal rights for determinations which are considered adverse (HHS-OBRA5).

If the HHS-OBRA9 indicates that the individual is approved for NF care and does not specify a specialized nursing facility, the individual may be transferred without further screening through the PASP program. If the nursing facility approval identified a specialized nursing facility, the individual cannot be transferred to another nursing facility without contact with HHS/contractor.

12-004.13A Processing of Final Determination: Within one business day of a PASP determination, HHS/contractor shall send the Form HHS-OBRA9 to the individual or his/her legal representative along with appeal rights for determinations which are considered adverse. Additional copies shall be forwarded to the following:

1. The individual's attending physician;
2. The discharge hospital, if applicable;
3. The CMHR and/or CBDDSP for individuals with MI and/or MR/RC who are denied NF placement, determined to require specialized services, or for whom specialized services are/were discontinued as a result of the determination; and
4. The Department of Department of Health and Human Services Finance and Support Medicaid Division.

12-004.13A1 Assurances: Within one business day of the final PASP determination or an RR/SCdetermination made under 471 NAC 12-004.11C, HHS/contractor will contact the referring source to explain the results of the determination and to request that these results be conveyed to the individual or his/her legal representative. For all determinations resulting in adverse consequences to the individual (e.g., denial of NF placement, determination of community-based service needs, determination of specialized service needs), HHS/contractor shall make the verbal contact described above and shall refer the individual to the CMHR or CBDDSP for individuals with MI and MR/RC, respectively. The CMHR or CBDDSP will, in turn, arrange contact with the individual or legal representative to coordinate service and/or placement options.

For residents determined to require inpatient psychiatric services, the PASP notification shall indicate need for the nursing facility to collaborate with the individual's attending physician to arrange such services.

12-004.13B Interdisciplinary Coordination: HHS/contractor, through Form HHS-OBRA9 (see 471-000-231), ensures the evaluation corresponds to the individual's current functional status as documented by the Level II evaluation and that each evaluation represents an interdisciplinary approach.

12-004.13C Nursing Facility Report - Appropriate: For an individual determined appropriate for nursing facility services, the facility shall receive a copy of the following:

1. Form HHS-OBRA5D, "Notification of Findings";
2. Form HHS-OBRA9, "Summary of Findings Report."

Form HHS-OBRA9 represents the final determination and recommendations. The nursing facility shall incorporate all recommendations into the plan of care and update facility records with current diagnosis and other evaluation information. HHS or its contractor shall retain a copy of the above documents as well as any other evaluative material or medical records documents upon which the final determination was based.

12-004.13D Nursing Facility Report - Inappropriate: For a nursing facility resident determined inappropriate for continued nursing facility services, the facility shall receive a copy of the following:

1. Form HHS-OBRA5, "Notification of PASP Findings" (see 471-000-227); and
2. Form HHS-OBRA9, "Summary of Findings Report" (see 471-000-231).

In addition, notification will be forwarded to Director of Nursing at the housing NF to alert him/her of the need to initiate discharge procedures defined under 42 CFR 483.130(m)(6) and to inform him/her that the CMHR and/or CBDDSP, as appropriate, will collaborate with the NF to identify placement options and to initiate discharge proceedings.

Form HHS-OBRA9 represents the final determination and recommendations. The nursing facility shall incorporate all recommendations into the plan of care and update facility records with current diagnosis and other evaluation information.

12-004.13E Choice: Individuals who have resided in a nursing facility for 30 continuous months may elect continued NF residence if the PASP evaluation determines that nursing facility care is inappropriate but specialized services, which can be provided by the State in the nursing facility, as needed. The 30 months of continuous residence is calculated back from the first PASP determination which found that the individual was not in need of NF care. The initial choice provision and alternative placement options shall be explained by the CBDDSP or the CMHR, as appropriate.

If the individual chooses to remain in the nursing facility under the choice provision, the nursing facility is required to incorporate the care recommendations into the overall plan of care as with any other individual who requires the Level II evaluation. Subsequent decisions of the choice option will be explained in written form to the individual or legal representative and will include a toll-free number if further explanation is needed or if the individual or legal representative chooses to reevaluate that option. Inquiries for further placement option discussion will be referred to the CBDDSP or the CMHR by HHS/contractor for an on-site discussion.

The "choice" stays with the individual until his/her status changes, e.g., a change in determination from inappropriate for NF care to appropriate for NF care, a denial of specialized services, or if the individual leaves the nursing facility, etc. When a new admission occurs, a new Level II determination will be made.

12-004.14 Referral for Community-Based Services: Referrals will be made by the HHS/contractor to the CMHR if the individual has a mental illness and/or the CBDDSP if the individual has a diagnosis of mental retardation or a related condition as per the following circumstances:

1. For any individual determined to be inappropriate for nursing facility services;
2. For any resident determined to require specialized services; and
3. For any resident formerly determined to require specialized services but whose subsequent evaluation determined that those services were no longer required. This notification serves to alert the CBDDSP or CMHP to discontinue service provision.

If the individual is considered to have a dual diagnosis, HHS/contractor shall send a copy of relevant information to both the CMHR and the CBDDSP, when appropriate. Form HHS-OBRA9 “Summary of Findings,” (see 471-000-231) and Form HHS-OBRA5, “Notification of Preadmission Screening Findings,” (see 471-000-227) will be forwarded with each of the above referral circumstances.

Written follow-up will be initiated by HHS/contractor through the Disposition Report Request to determine the status of each of the individual referred for community-based services.

The determination regarding the provision of services must be based upon standards governing the service-delivery program, not those found within this chapter.

12-004.15 Appeal Process: At the conclusion of each PASP evaluation, HHS/contractor shall issue written appeal rights and instructions for requesting a fair hearing, as defined under 42 CFR 431, Subpart E and 483, Subparts C and E. These allow the individual or legal representative to appeal any determination rendered through the PASP process which is felt to adversely affect the evaluated individual.

The individual or legal representative will be instructed to contact HHS/contractor for information on appeals and to forward a written request for an appeal to the Department of Health and Human Services Finance and Support within 90 days of the date of the PASP determination notice.

12-005 Senior Care Options (SCO): The Department of Health and Human Services Finance and Support (HHSFS) contracts with area agencies on aging (AAA) to operate SCO. The AAA, as Senior Care Options (SCO), is responsible for accurately determining the Nursing Facility (NF) level of care of each person evaluated and providing information about service options, as appropriate for the individual's situation. SCO may obtain information to be used in the evaluation decision from a variety of sources, including but not limited to observation; interview of older person, family members, nursing facility staff, hospital staff; and review of medical records. SCO is responsible for making the final decision.

12-005.01 Persons Eligible: To be eligible for evaluation through SCO, a person must meet each of the following conditions:

1. The person must be 65 years of age or older;
2. The person must be a Medicaid client or have applied for Medicaid;*
3. The person must be requesting Medicaid funding to cover nursing facility services;
4. The person must not require a PASP Level II screen; and
5. The person must be a nursing facility resident or considering nursing facility admission as evidenced by one of the following circumstances:
   a. The person is an emergency room patient or has been admitted as a hospital inpatient and has a discharge plan that indicates admission to a nursing facility;
   b. The person lives in any less-restrictive living arrangement in the community and has applied for nursing facility admission;
   c. The person has entered a nursing facility on a short-term basis for rehabilitative or convalescent care and is a Medicaid recipient; or has applied for Medicaid. The person may have insurance which will cover part or all of the cost of the nursing facility care; or
   d. The person is a private pay nursing facility resident who has applied for Medicaid.

*"Applied for Medicaid" means that a completed, signed application has been received by HHS local office staff.

Admission to swing bed services in 471 NAC 12-009.08 is excluded from the SCO process; these admissions are approved as described in 471 NAC 12-007.05H.

12-005.01A Special Circumstances Not Evaluated/Screened: SCO staff will not evaluate the care needs of aged Medicaid clients who -

1. Return to the same NF after hospital, Medicare skilled care, or swing-bed providing that the NF has not indicated discharge on the MDS system;
2. Are current Medicaid NF residents who then convert to a hospice program;
3. Are receiving NF care which is wholly or partially paid through Medicare;
4. Are admitted to swing beds (471 NAC 12-009.08);
5. Are currently-approved Medicaid NF residents who become age 65;
6. Transfer from one NF to another NF;
7. Have a positive PASP Level I screen and will be referred instead to an appropriate HHS contractor or program. (However, SCO will be involved by generating Form MC-9-NF after receiving the written authorization from the contractor.);

8. Are currently involved with the Aged and Disabled Waiver program through HHS. (These persons have already been determined NF level of care so additional evaluation is not needed. If such a person chooses NF admission, SCO will generate Form MC-9-NF.);
9. Receive Medicaid services through a Medicaid managed care plan and enter the NF on a short-term basis (and will, therefore, continue with the managed care plan.) This does not apply to clients enrolled in a primary care case management under Medicaid managed care; they are appropriate for SCO evaluation; or
10. Are admitted to a bed covered by a special Medicaid contract (e.g., 471 NAC 12-014).

12-005.02 Qualifications of Evaluation Counselors: Evaluations will be performed by individuals who meet the minimum qualifications contained in Nebraska's Health Care Financing Administration – approved Aged and Disabled waiver application.

12-005.03 Evaluation Format: Evaluation will be conducted through the use of a common evaluation tool, Form DSS-14AD, "Functional Criteria" (see 471-000-48). The evaluation tool reflects each area of NF level of care criteria (471 NAC 12-003.02), the amount of assistance required and the complexity of the care.

12-005.04 Referral

12-005.04A Referrals from NF Staff: In the case of a nursing facility referral, the nursing facility shall notify SCO if -

1. A person who is Medicaid-eligible has applied for admission to the nursing facility;
2. A person who has a Medicaid application pending has applied for admission to the nursing facility; or
3. A person who is currently a resident has applied for Medicaid coverage.

12-005.04B Minimum Referral Information: SCO accepts referrals from nursing facilities, hospitals for hospital inpatients or emergency room patients, clients/families who have contacted an NF to request admission, and HHS eligibility or waiver staff who are working with an older person who is seeking Medicaid funding for NF services. The following is the minimum information SCO needs to process a referral for screening/evaluation:

1. The name of the person making the referral, his/her position, and telephone number;
2. The name of the nursing facility involved, if different than the referral source;
3. The name, date of birth, and social security number of the person to be evaluated;
4. The date and time the referral is being made; and
5. Whether this is considered an emergency.

12-005.04C Receiving Referrals: When the SCO counselor receives a referral to evaluate an applicant for admission to a nursing facility, s/he will begin to collect the information outlined on the evaluation form. Information may be collected either in person or through telephone interviews. If only telephone contact is used, two information sources are preferred. Based on the information gathered through the evaluation, the SCO counselor determines whether the applicant meets nursing facility level of care criteria.

12-005.04D Evaluation Time Frames

12-005.04D1 Open Medicaid Status: The Senior Care Options counselor shall document the date and time referral received from an NF, hospital, or other referral source for a person who is currently eligible for Medicaid. "Open" Medicaid means that financial eligibility for Medicaid was earlier determined by HHS staff and remains effective on the date of referral to SCO. SCO staff shall complete a level of care evaluation within 48 hours of this referral date. If the evaluation is not completed within 48 hours, the applicant for admission shall be determined to be appropriate for admission until an SCO evaluation is completed and any required notice is given.

For persons with open Medicaid status who meet the NF functional criteria, the earliest possible date of Medicaid payment for NF services is the date of referral to SCO. Note: Financial eligibility for Medicaid is determined only by designated HHS staff throughout the state. The SCO determination relates only to Medicaid authorization specifically for nursing facility payment.

Hospitals may contract with their Area Agency on Aging to participate in the professional evaluation procedure. This procedure allows patients with health care needs which clearly meet set criteria to obtain prior Medicaid authorization for admission to a nursing facility. SCOs will furnish each contracting hospital with a schedule of information on how to access SCO Counselors at all times, including evenings, holidays, and weekends.

12-005.04D2 Pending Status: The Senior Care Options counselor shall assign a request date upon receipt of referral for a person whose Medicaid application is in a pending status. "Pending" Medicaid status means that a completed, signed application for the Nebraska Medical Assistance Program (i.e., Medicaid) has been received in the local HHS office, but a final decision about financial eligibility has not yet been made by HHS staff. SCO staff have flexibility in the 48-hour time limit during this pending period to allow visits to be consolidated and/or pre-arranged for time and cost savings and shall document a referral date accordingly. The 48-hour time frame applies if the evaluation has not been completed by the date Medicaid eligibility is determined.

For persons who are found to meet the NF functional criteria while Medicaid eligibility is pending, the earliest possible date of Medicaid payment for NF services is the eventual effective date of Medicaid eligibility.

12-005.04D3 After Pending Status: If a current NF resident applies for Medicaid without informing the NF and no SCO referral is made during the pending period, the NF must make an immediate referral to SCO when information is received that Medicaid has been approved. SCO shall perform an evaluation within 48 hours of the delayed referral and, if the following conditions are met, authorize payment for NF services retroactive to the first date of Medicaid eligibility:

1. The nursing facility has in place a process to inform private pay clients and their families that the NF must be informed when a Medicaid application is made;
2. The nursing facility makes a referral to SCO immediately upon receipt of information about the opening of the Medicaid case. At the time of this referral, the NF shall provide information on the date and means by which information about Medicaid eligibility was obtained.
3. The resident meets the NF level of care criterial.

Both SCO and NF staff are encouraged to work with HHS Medicaid eligibility staff to set up a process of informing either SCO or the NF when an NF resident applies for Medicaid.

12-005.05 Professional Evaluation: Any hospital willing to enter into an agreement to perform professional evaluations and who performs according to the requirements of the contract shall be given the authority to conduct a professional evaluation in lieu of SCO performance on the evaluation in cases in which an eligible person has chosen to transfer from the hospital to a nursing facility.

The hospital staff who have been authorized by SCO to conduct a professional evaluation will provide evaluation information to the SCO within 24 hours of collection. The final determination of level of care need will be made by SCO staff based upon the information provided by the professional evaluation prior to hospital discharge. SCO staff will indicate on Form MC-9-NF if a person has been authorized for Medicaid coverage subsequent to a professional evaluation.

Professional evaluation is appropriate when -

1. The hospital has a signed agreement to participate in this process. The agreement contains details of the designated staff via an attachment which contains staff names and/or positions or designed hospital departments;
2. The person to be evaluated is in the hospital's emergency room or is a hospital inpatient;
3. The patient's condition clearly indicates NF care. (If there is a question about care level, hospital staff must make a referral to SCO in the usual manner.); and
4. Hospital staff have presented options to the older person/family and they choose NF services. (If the person/family wishes to explore home care options, hospital staff must make a referral to SCO in the usual manner.)

Any material failure to perform under the terms of such agreement shall be grounds to terminate such contract with the hospital.

12-005.06 Outcomes of the Evaluation:

12-005.06A NF Level of Care Met: If the SCO counselor determines that the applicant meets nursing facility level of care criteria and the client chooses to receive NF services, the SCO counselor completes Form MC-9-NF (see 471-000-203) which authorizes Medicaid payment for nursing facility care.

12-005.06B NF Level of Care Not Met: If the evaluation counselor determines that the applicant does not meet nursing facility level of care, the SCO counselor notifies the applicant of that determination. Persons who are found to be ineligible for Medicaid reimbursement for nursing facility service will be sent a notice of denial (Form DSS-6) (see 471-000-23) by the SCO counselor. A copy of the notice will be sent to the NF for clients currently eligible for Medicaid.

12-005.06C Possible Options: Depending on the findings of the evaluation, one of four options for provision of service will be pursued. The options are:

1. Nursing facility admission;
2. Rehabilitative/convalescent care (short-term approval);
3. Home and community-based services through the Medicaid Aged and Disabled Waiver and/or other community resources; and
4. No service required.

Medicaid payment for nursing facility services will only be available to those who are found to require nursing facility level of care. They will have the option of entering a nursing facility or exploring home and community-based care services.

If the evaluation determines that there is a need for post-hospitalization rehabilitative or convalescent care, the SCO counselor may provide short-term or time-limited authorization of nursing facility care. A review of the client's condition will be made prior to the end of the term to determine future level of care. This option would be available only to those who meet nursing facility level of care criteria.

Managed community care is available regardless of the need for nursing facility level of care. For those persons who meet nursing facility level of care, but who choose to pursue community-based options, the Aged and Disabled home and community-based services waiver will be an option for service payment. That option is not available to persons who do not meet nursing facility level of care. Those persons may be referred to the Nebraska Care Management Program.

12-005.06D Assessment: Whenever possible, given each individual's situation, the SCO counselor shall determine whether the person wishes to explore community service options. SCO shall make a referral to the Aged and Disabled Waiver when –

1. The results of the evaluation indicate that the client's level of care is appropriate for nursing home placement;
2. The client chooses to explore community long-term care services; and
3. The client, in the opinion of the evaluator, is capable of making effective use of community long-term care services.

12-005.07 Documentation: SCO shall maintain documentation that includes:

1. Information which indicates that the individual is eligible for evaluation through SCO;
2. Notations of information leading to findings;
3. A completed evaluation instrument;
4. Time lines of action from the time of referral to completion of screening and notification of findings.

12-005.08 Billing: Each Senior Care Options program site shall sign Form MC-19, "Medical Assistance Provider Agreement (see 471-000-90)," to establish their Medicaid case management provider status. The site may then bill HHS for screening activities. Information included in a billing document will include project site, client name, SSN, service month and year, date submitted, signature of authorized person unless submitted electronically, place of service, type of service, unit rate, and total charge.

Billing documents will be submitted to HHS for payment.

12-005.09 Notices and Appeals

12-005.09A Form DSS-6, "Notice of Action" (see 471-000-23): SCO staff send this form (or other HHS-approved form which contains the same information) to each client/family (with copies to other appropriate, interested parties, such as the NF, if the action being taken affects them), to inform the client of SCO denial. “Denial” is the appropriate action when there is no existing authorization for Medicaid payment of NF services and no authorization will be given to fund services. “Denial” is used when a screen/evaluation has been done and the person does not meet the set NF level of care criteria.

SCO also uses the form to notify clients of short-term NF authorization periods. If short term authorization is appropriate for a person with pending Medicaid status, SCO staff shall note on the form that the payment is contingent on Medicaid eligibility.

12-005.09B Timely Notice for NF Residents: To maintain consistency with current Medicaid practices in regard to nursing facility services and to acknowledge federal requirements which prescribe notices in nursing facilities, persons who are already NF residents with Medicaid funding and no longer meet the criteria for NF level of care must be allowed up to 30 days from the date of the notice. This is not expected to occur often, as most persons evaluated have not previously been receiving Medicaid NF funding so they are "denied" and Medicaid never provides funding. However, there are a few instances where "termination" is appropriate because Medicaid NF funding is being stopped. Examples may include when short-term approval is not spelled out at admission or SCO evaluation is not completed within 48 hours and the person is admitted to a facility.

Note: A person who has been in the facility under Medicare-Medicaid copay is not considered a resident; Medicaid payment for this type of service is not authorized through the MC-9-NF process. Medicare provides notice that funding will stop. A person evaluated following the end of Medicare approval and found to NOT meet NF criteria would be denied any payment to the NF just as any new admission.

12-005.09C Appeals: Clients may appeal any action or inaction of SCO by following standard Medicaid appeal procedures as defined in 465 NAC 6-000.

If an appeal is held following denial of NF services based on not meeting level of care criteria and the action is upheld, SCO shall refer the person to appropriate services. No Medicaid payment would be made to the NF on behalf of this person since no approval was ever provided.

If an appeal was filed within time frames following termination of NF services, Medicaid payment will be made according to the content of the Finding and Order.

12-006 Local Office Staff Responsibilities: Regulations in this section apply to clients not covered by the SCO.

12-006.01 Plans for Care and Services: Local office staff shall assist in planning and evaluating care needs cooperatively with the client, his/her family, and the attending physician, based on medical and social information recorded in the case record. To most appropriately meet clients' needs, local office staff must -

1. Be knowledgeable of each facility's type and its ability to provide appropriate services to meet the individual client's needs;
2. Be knowledgeable of the following alternate care levels available:
   a. Companion and other community in-home or respite services;
   b. Homemaker services;
   c. Chore services;
   d. Personal care aide services;
   e. Home health services;
   f. Assisted living facilities;
   g. ICF/MR;
   h. Nursing facility (including swing beds); and
   i. Community-based mental health, mental retardation/ developmental disability, and alcohol/drug abuse services.
3. Advise the client, the family and/or guardian, and physician of the alternatives available;
4. Assist the client and/or the family in selecting the most appropriate services/facility;
5. Implement admission procedures based on the SCO procedures, the physician's recommendations, PASP procedures, and NMAP's criteria for the level of care needed by the client; and
6. Notify the client of any change on Form IM-8 (see 471-000-68), IM-8B, or DSS-6 (see 471-000-23).

Local office staff shall assist and/or advise the client, family, and/or guardian with the initial placement and at any time that a change of facility is necessary due to changes in medical status, Central Office recommendations, or when the client desires to transfer to a location close to a family member.

Local office staff are not responsible for telephone calls, transportation, etc., for clients who chronically request facility-to-facility transfers without valid and documented reasons for the transfer. If valid documentation does not exist, the client, family, or guardian is responsible for contacting and making arrangements with the receiving facility.

Note: The Department encourages both facility and local office staff to identify contact persons and to establish a working relationship with that contact person to facilitate timely communication.

Referrals: Local office staff shall refer any client or applicant age 65 or older to Senior Care Options for assessment when nursing facility care is requested.

12-006.02 Prior Authorization Requirements: NMAP shall pay for a nursing facility service only when prior authorized. Each admission must be separately prior authorized. See 471 NAC 12-001.04, definition of admission.

12-006.02A Admission Form MC-9-NF, "Prior Authorization for Nursing Facility Care": Within 15 days of the date of admission to the nursing facility or the date eligibility is determined, for clients not assessed by SCO, local office staff shall process Form MC-9NF.

The Medical Review shall determine medical necessity using above information and information from the resident assessment for the nursing facility level of care and return the forms to the local office for distribution (471 NAC 12-003.02).

Within ten working days after the Medical Review determination has been received, local office staff shall distribute all copies of Form MC-9-NF.

12-006.02B Time Frame for Physician's Admission History and Physical: When the client is admitted to a nursing facility, local office staff shall work with facility staff to ensure that -

1. The client has had a physical examination within 48 hours (two working days) after admission unless an examination was performed within five days before admission; and
2. The history and physical can be documented on Form DM-5 (see 471-000-221); Hospital H&P; or any form used by the physician.

12-006.02C Physician's Initial Certification (Form DM-5 or Form MC-9-NF): The physician's certification on Form DM-5 (see 471-000-221) or Form MC-9-NF (see 471-000-203) must be signed as follows:

1. For clients already eligible at the time of admission, Form DM-5 or Section III of Form MC-9-NF must be completed and signed by the physician; or
2. For clients who became eligible after admission, Form DM-5 or Section III of Form MC-9-NF must be completed prior to requesting prior authorization for nursing facility care.
3. Form DM-5 or MC-9-NF must be signed by a physician (if a physician signature stamp is used, the physician shall initial the stamped signature). Physician's assistant or registered nurse signature or initials are not acceptable; and
4. Form DM-5 and/or Form MC-9-NF may be maintained in the client's medical record in the facility or building when the resident resides or in the patient account file in the business office.

12-006.02D Distribution of Annual History and Physical Form: Admission/current history and physical form must be distributed as follows:

1. The nursing facility retains the original for the client's record and sends two copies to the local office;
2. Local office staff retain a copy in the client's case record; and
3. Local office staff send a copy to the Central Office.

12-006.03 Use of Form MC-10: Form MC-10 (see 471-000-211) adjusts (corrects, deactivates, or reactivates) the MC-9-NF payment authorization.

The local office completes the Form MC-10 with the information received from the NF/Swingbed/ICF/MR. The Department encourages facilities to communicate frequently with the hospital discharge planner to keep aware of resident's status and to inform the local office worker.

Examples of Form MC-10 usage include using Form MC-10 to correct information on the processed Form MC-9-NF that is in error, i.e., an incorrect admission date, an incorrect Medicaid payment effective date, an incorrect Medicare coverage date, an incorrect provider number, or an incorrect discharge date.

Scenarios:

A client is hospitalized for over 15 days
*deactivate the authorization effective the 16th day
*reactivate the authorization effective the date client returns to NF

A client is hospitalized then admitted to a Medicare bed in another NF
*deactivate the authorization effective the date admitted to Medicare bed
*reactivate the authorization effective the date client returns to original NF

A client is hospitalized, then admitted to the hospital Swingbed
*deactivate the authorization effective the date admitted to Swingbed
*reactivate the authorization effective the date client returns to NF

A client returns from the hospital on Medicare
*deactivate the authorization effective the date Medicare coverage begins (MEDICARE DAYS INCLUDE COINSURANCE DAYS)
*reactivate the authorization effective the first non-Medicare covered day

A Medicare/Medicaid client in a NF is admitted to Hospice in the NF
*deactivate the authorization effective the date admitted to Hospice
*reactivate the authorization effective the date discharged from Hospice to the NF (this is a rare occurrence, but it does happen)

A client returns home or is discharged to an alternate level of care (board and room, residential care, domiciliary care, an adult family home, a group home)
*deactivate the authorization effective the date the client leaves the NF or the date Medicaid is no longer paying for a therapeutic home visit if THV days are being used for a home trial to determine if client can live at home with supportive services

A client expires in the Facility or in the case of a NF bedholding while in acute care in a hospital, the date the client expires in the hospital (if not over the 15 days of hospital bedhold)
*deactivate the date client expires

12-006.04 Facility-to-Facility Transfer: When a Medicaid client is transferred from one facility to another (NF or ICF/MR), the local office worker shall complete Form MC-10 (see 471-000-211) to close the prior authorization for the previous facility for the date of the transfer.

The local office worker shall follow the procedures in 471 NAC 12-006.02 for the new facility.

12-006.04A Procedures for Level of Care Change: The following steps must be completed for the deinstitutionalization of a NF client:

1. Medical Review recommends a change in level of care after reviewing the client's medical and social care needs and sends a notification letter to the client's attending physician, giving him/her an opportunity to respond, and -
   a. If the physician presents medical justification for continued nursing facility care, the recommendation may be withdrawn; or
   b. In the absence of medical justification, the recommendation becomes final.
2. Medical Review sends a notification letter to the facility and the local office;
3. Medical Review sends Form ASD-100 (see 471-000-28) to the client's local office;
4. Upon receipt, the facility establishes and documents an appropriate discharge plan to assist the client in preparing for an alternate living arrangement;
5. Medicaid payment for long term care is approved for up to 60 days from the date the final determination is made. During this time, local office staff shall -
   a. Notify the client on Form IM-8 (see 471-000-68);
   b. Assist with making alternate living arrangements, if requested; and
   c. Complete Form ASD-100 and return the form to the Medicaid Division.

12-006.04B Inappropriate for NF Care: For those clients who, at the time of Medical Review determination, no longer meet NF criteria (471 NAC 12-003.02) for nursing facility services, the Medical Review shall limit Medicaid payment for up to a maximum of 30 days, beginning with the date the Medical Review determines that nursing facility care is inappropriate.

Time-limited authorizations exceeding 30 days may be made based on the client's potential for discharge as determined by the Medical Review.

12-007 Responsibilities of Nursing Facilities: Nursing facilities shall provide staff of the Department of Health and Human Services Finance and Support and its contractor, and staff of Department of Health and Human Services with the data, forms, and cooperation necessary to admit, plan for, evaluate the medical care needs of, and make determinations on the appropriateness of nursing facility services for each Medicaid client as required by the Nebraska Department of Health and Human Services Finance and Support Manual and federal Medicare and Medicaid regulations and program instructions. Note: The Department encourages both facility and local office staff to identify contact persons and to establish a working relationship with that contact person to facilitate timely communication.

12-007.01 Clients Participating in the Nebraska Health Connection: Nursing facilities located in counties covered by the Nebraska Health Connection (Medicaid Managed Care) shall check the client's managed care status prior to admission.

The Managed Care Plan manages the client's primary care services including "skilled" nursing facility level of care as defined by Medicare in 42 CFR 409 Subpart D.

For purposes of the Nebraska Health Connection, "skilled nursing services" are those nursing facility services provided to Medicaid eligible clients which are skilled nursing/skilled rehabilitative services as defined by Medicare and the nursing facility admission is expected to be temporary. "Custodial" services are those nursing facility services as defined in 471 NAC 12-003 and the nursing facility admission is expected to be permanent.

This applies ONLY to the admission of clients who are not eligible for Medicare Part A coverage. The facility must verify Medicaid eligibility and the client's Managed Care participation by calling the Nebraska Medicaid Eligibility System (NMES) or electronically using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). See 471-000-124.

If the client is not enrolled in a Managed Care Plan, the NF may proceed with the admission as outlined in this chapter.

If the client is enrolled in a Managed Care Plan on the date of admission, the NF must call the client's Managed Care Plan. The Primary Care Physician in coordination with the Managed Care Plan will make a determination of the level of care the client requires ("skilled"or "custodial"). The Managed Care Plan will notify the Department of Health and Human Services Finance and Support.

If the client's level of care is determined to be "skilled," the Plan will be responsible for medical management of the Medicaid services the client requires. Arrangement for payment must be made with the HMO Managed Care Plans. If the level of care is determined to be "custodial," proceed with the current process for Department of Health and Human Services Finance and Support payment.

12-007.01A Admission of Managed Care Clients:

1. When a Medicaid-eligible, managed care client is admitted to a nursing facility, the Managed Care Plan in coordination with the Primary Care Physician (PCP) will determine the level of care the client requires - skilled/rehabilitative or custodial/maintenance using Medicare's definition for skilled care.
   When the level of care the client requires is skilled/rehabilitative, the client will not be disenrolled from managed care. The Plan will continue medical management of the client. The HMO Plans will be financially responsible for the skilled care service. Claims for a client enrolled in the Primary Care + Plan will be sent to the Department of Health and Human Services Finance and Support.
2. When the client is admitted to a nursing facility for custodial care, the Department of Health and Human Services Finance and Support will assume financial responsibility for the facility charges. The Plan will continue the medical management of the client for all services included in the basic benefit package. All services included in the basic benefit package will be the financial responsibility of the HMO Plans until disenrollment of the client from managed care. Claims for clients enrolled in Primary Care + Plan will be sent to the Department of Health and Human Services Finance and Support. Disenrollment from managed care will occur the first day of the month following the change in the living arrangement code. For changes in the living arrangement code entered the last five working days of the month, disenrollment will not occur until the beginning of the next month (current month + 1).
3. When the client is admitted to a nursing facility for "custodial" care and the client's primary care physician (PCP) does not see clients at the facility, the Plan will work cooperatively with the client and nursing facility staff to locate another physician for the client until disenrollment.
4. Clients residing in a nursing facility in an assisted living situation, at a domiciliary or room and board rate, are not residents of the nursing facility. These clients will not be disenrolled from managed care unless the Plan determines that a change in level of care is appropriate.

12-007.02 Preadmission Screening: When an individual requests admission to a Medicaid-certified bed in a nursing facility, the facility shall implement the PASP as defined in 471 NAC 12-004. An individual who has an indication or diagnosis of mental illness meeting SMI definition, mental retardation or a related condition, or a dual diagnosis may be admitted to a nursing facility only when the individual is determined to be appropriate for nursing facility services through the PASP.

The effective date of payment for nursing facility services for a Medicaid-eligible client can be no earlier than the date that the client is found to be appropriate for NF services through the PASP.

Note: For Senior Care Options preadmission, see 471 NAC 12-005.

12-007.02A Level I Evaluation: The Level I Screen is required for any individual who -

1. Is applying for first time admission to a Medicaid certified NF;
2. Was previously formally discharged from a NF and is applying for admission to the same or another Medicaid certified NF;
3. Is being admitted or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment (e.g., crisis unit);
4. Was evaluated through the PASP Level II process and was not admitted to a Medicaid certified NF within 90 days of the Level II;
5. Was screened as a Negative Level I but whose placement was delayed longer than 12 months from the previous Level I screen;
6. Was screened as a Negative Level I but whose behaviors and/or symptoms now suggest the presence of mental illness and/or mental retardation/related conditions as defined under 471 NAC 12-004.05 of this chapter.
7. Was approved under 471 NAC 12-004.07 as a short term categorical admission or an Exempted Hospital Discharge and whose stay is expected to extend beyond approved time frames.

Any individual who has not been previously evaluated under the PASP requires a Level I evaluation; likewise, any individual whose changing condition now requires the s/he be reviewed for the appropriateness of nursing facility care under the PASP requires a Level I evaluation.

The nursing facility shall ensure that Form HHS-OBRA1, "Identification Screen" (see 471-000-223) is completed accurately for each individual requesting nursing facility services. Form HHS-OBRA1 is completed by a designated health professional employed by the nursing facility or by a designated health professional in settings other than the nursing facility in anticipation of the individual's need for nursing facility services.

Form HHS-OBRA1, "Identification Screen," is used to determine, based on medical and other supportive information from a licensed health care practitioner, whether an individual requesting nursing facility services has an indication or diagnosis of mental illness, mental retardation or a related condition, or a dual diagnosis and requires a Level II evaluation.

12-007.02B Transfers: A nursing facility-to-nursing facility transfer does not require the completion of a new Form HHS-OBRA1 (see 471-000-223). The discharging facility shall send a copy of the most recent Form HHS-OBRA1 and applicable PASP information if a Level II evaluation was performed to the admitting facility at the time of transfer. The discharging facility shall notify the HHS/contractor of the transfer if a Level II evaluation was performed.

Note: Senior Care Options staff will not reevaluate the level of care needs of a person transferring to a second nursing facility. However, SCO must be informed of the transfer to generate Form MC-9-NF (see 471-000-203) for the receiving NF.

12-007.02C Exempted Hospital Discharge Stays That Exceed 30 Days: If an individual who qualifies as an exempted hospital discharge is later found to require more than 30 days of nursing facility care, the nursing facility shall contact the HHS/contractor and shall send Form HHS-OBRA1 to HHS/contractor by the 30th day. If a Level II evaluation is indicated, the facility shall also send to the HHS/contractor by the 30th day with Form HHS-OBRA1:

1. Form HHS-OBRA8 (see 471-000-221);
2. Form DM-5 (see 471-000-230) or a history and physical;
3. A Social History; and
4. A copy of Form DM-5-LTC.

If a Level II evaluation is indicated, a PASP review must be conducted within 40 calendar days of the individual's admission.

Note: Senior Care Options staff will not reevaluate the level of care needs of a person transferring to a second nursing facility. However, SCO must be informed of the transfer to generate Form MC-9-NF for the receiving NF.

12-007.02D Negative Screens: If a Medicaid-eligible client does not require a Level II evaluation and is admitted to the nursing facility, the facility shall -

1. Send a copy of Form HHS-OBRA1 to the HHS/contractor;
2. Send a copy of Form HHS-OBRA1 to the client's local office along with Form MC-9-NF, the annual/current H&P, and the medication/treatment sheet; and
3. Retain a copy of Form HHS-OBRA1 in the resident's permanent nursing facility record.

If a non-Medicaid-eligible individual does not require a Level II evaluation and is admitted to the nursing facility, the facility shall send a copy of Form HHS-OBRA1 to the HHS/contractor and retain a copy in the resident's permanent nursing facility record.

12-007.02E Categorical Determinations and Exemptions: If the results of a Level I evaluation, based upon current medical documentation, indicate that an individual has a diagnosis or an indication of mental illness, and/or mental retardation or a related condition, and meets one of the following conditions, the individual qualifies for a "categorical determination" or an exempted hospital stay and does not require an on-site Level II evaluation prior to NF admission. Admission to the nursing facility for an individual qualifying under a categorical determination or Extended Hospital Stay may proceed only after approval is provided by the HHS contractor. Options include -

1. Categorical Emergency Seven Day - The individual is being admitted pending further assessment in an emergency situation requiring protective services for a period not to exceed seven calendar days. Before admission can occur, documentation or verbal description of emergency need must be provided to, and approval must be secured by, HHS/contractor. Forms HHS-OBRA1 (see 471-000-223) and HHS-OBRA1a (see 471-000-226) must be submitted along with the above.

If it is determined that the individual's stay in the NF will continue beyond the approved seven-day time frame, the receiving facility must contact the HHS contractor as soon as the determination is made that continued stay will be required and no later than the seventh calendar day following admission, in order to arrange an on-site Level II evaluation.

2. Categorical Respite 30 Day - The individual is being admitted to provide respite care for a period not to exceed thirty (30) calendar days for in-home caregivers to whom the individual is expected to return. Before admission can occur, documentation supporting the need for respite services placement must be provided along with Forms HHS-OBRA1 and HHS-OBRA1a to HHS/contractor.

   If it is determined that the individual's stay in the NF will continue beyond the approved 30-day time frame, the receiving facility must contact the HHS-OBRA Unit or its contractor as soon as the determination is made that continued stay will be required and no later than the 13th calendar day following admission, in order to arrange an on-site Level II evaluation.
3. Categorical Progressed Dementia with MR/RC: The individual has mental retardation or a related condition along with a co-occurring diagnosis of progressed dementia, Alzheimer's disease or related disorder. Both of the following must also be present: The diagnosis of dementia, Alzheimer's disease or related disorder must be considered the <u>primary</u> diagnosis and the individual must be considered to be in the advanced stages of this condition and no longer able to meaningfully participate in or benefit from a program of specialized services. Before admission can occur, medical records information which supports that the individual qualifies under this criterion must be provided to the HHS/Contractor along with Forms HHS-OBRA1 and HHS-OBRA1a.
4. Categorical Serious Medical - The individual's medical condition renders him/her unable to benefit from a plan of specialized services and clearly meets criteria for NF care. Applicable conditions include: Coma, Ventilator Dependence, Brain Stem Injury, End-Stage Medical Condition. In order to qualify, medical records information which support that the individual qualifies under this criterion must be provided along with Forms HHS-OBRA1 (see 471-000-223) and HHS-OBRA1a (see 471-000-226) to HHS/contractor before the individual's admission can occur.
5. Exempted Hospital Discharge - Federal regulations also offer an exemption from the Level II PASP process for individuals with mental illness and/or mental retardation/related conditions who meet Exempted Hospital Discharge criteria discussed in 471 NAC 12-004.03.

12-007.02E1 Documentation of Categorical Determinations: The facility shall send Forms HHS-OBRA1, HHS-OBRA1a, and documentation supporting the categorical determination to the HHS/Contractor before admission for an individual with mental illness, mental retardation, or a relation condition, or a dual diagnosis may occur under the categorical determination provision:

1. Categorical Emergency 7 Day - The individual is bring admitted pending further assessment in an emergency situation requiring intensive services for a period not to exceed seven calendar days.
2. If Form HHS-OBRA1a indicates that the individual will be in facility for a convalescent stay, the facility shall attach documentation supporting the short stay to the form.
3. If Form HHS-OBRA1a indicates terminal illness, the facility shall attach the physician's certification of terminal illness to the form.
4. If Form HHS-OBRA1a indicates that the individual has any of the conditions that limits the individual's participation in or benefit from mental health services, mental retardation/developmental disability services, or specialized services, the facility shall attach documentation that explains the limitation to the form.
5. If Form HHS-OBRA1a indicates an emergency situation requiring protective services, the facility shall attach documentation supporting that the situation required protective services to the form.
6. If Form HHS-OBRA1a indicates a respite stay, the facility shall attach documentation supporting the need for respite services to the form.
7. If Form HHS-OBRA1a indicates that the individual has a diagnosis of mental retardation or a related condition and Alzheimer's, dementia, or a related disorder, based on a neurological examination, the facility shall attach a copy of the neurological examination report, as determined by the physician, to the form.

Documentation that supports the categorical determination may include, but is not limited to, a current history and physical, physician's order, discharge plan, etc.

12-007.02F Individuals Who Require a Level II Evaluation: Following a Level I determination that the individual requires a Level II evaluation, Form HHS-OBRA5 (see 471-000-227) will be issued to the individual or his/her level representative to notify the individual that s/he has an indication or diagnosis of mental illness, mental retardation or a related condition, or a dual diagnosis and that s/he is being referred for a Level II evaluation. Form HHS-OBRA5 will be issued upon receipt of Form HHS-OBRA1 (see 471-000-223) and required medical/social information by the HHS/contractor. The nursing facility, hospital, or other party shall complete the following at the time of request for admission and send to HHS/contractor:

1. Form HHS-OBRA1;
2. Form HHS-OBRA8 (see 471-000-230);
3. A copy of the social history;
4. All copies of Form DM-5-LTC (see 471-000-222) or a copy of Form MC-75 (see 471-000-43) or Form MC-75Q (see 471-000-44); and
5. A copy of Form DM-5 (see 471-000-221) or current history and physical.

The nursing facility retains a copy of Form HHS-OBRA1 and HHS-OBRA8 in the individual's permanent nursing facility record.

12-007.02G Medicaid Payment: If a Medicaid-eligible client requires a Level II evaluation and is admitted to the nursing facility, Medicaid payment for NF services can begin no earlier than the date of the PASP final determination, following the Level II evaluation.

12-007.02H Admission to a Nebraska Facility From Another State: The nursing facility shall notify the SCO of potential admissions. If a Level II evaluation is required, HHS/contractor shall complete Level II evaluation prior to admission.

12-007.02J Admission of Nebraska Residents to Out-of-State Facilities: If a Nebraska Medicaid client is being admitted to an out-of-state facility, the preadmission screening process (including the Level II evaluation, if required) must be completed before the client leaves the state.

12-007.02K Level II Evaluation: The Level II evaluation provides -

1. A determination of whether the individual has mental illness, mental retardation or a related condition, or a dual diagnosis;
2. A determination of whether the level of services provided by a nursing facility is appropriate to meet the individual's need(s); and
3. A recommendation for services that addresses the individual's need(s) in the nursing facility or in an alternative placement, without regard to the availability of services.

The following steps are required to complete the Level II evaluation.

12-007.02K1 Returning From Receiving Specialized Services for Mental Illness: If an individual is returning to a nursing facility from receiving specialized services for mental illness and a Level II evaluation is indicated, s/he requires a new Level II evaluation unless the current admission is within three months of the Level II evaluation OR the determination is made that the individual's condition/needs have not significantly changed. The hospital shall contact HHS/contractor to obtain this exception.

12-007.02K2 Facility Action: For each individual who requires a Level II evaluation, the nursing facility, hospital, or other party shall obtain the following medical information and send it with Form HHS-OBRA1 (see 471-000-223) and Form HHS-OBRA8 (see 471-000-230) to HHS/contractor.

1. A copy of Form DM-5, "Physicians Confidential Report," (see 471-000-221) (completed by the individual's physician) which contains current medical information necessary to determine the kind and amount of medical care needed, or a copy of a current history and physical. Form DM-5 is also used to establish a diagnosis of dementia, Alzheimer's disease, or related disorder according to DSM-IIIR criteria and based on a neurological examination.

2. Form DM-5-LTC, "Long Term Care Evaluation" (see 471-000-222), (in its entirety) which contains current nursing, social, and emotional, etc., information necessary to establish the level of care required by the individual (Form DM-5-LTC is completed by an RN or LPN) or Form MC-75 (see 471-000-43) or Form MC-75Q (see 471-000-44).
   Note: Forms DM-5 and DM-5-LTC must contain the necessary medical information required for the medical and nursing portion of the Level II evaluation (i.e., medical history, neurological evaluation, comprehensive drug history, and response by the individual with mental retardation to specified drugs (i.e., hypnotics, antipsychotics (neuroleptics), mood stabilizers and anti-depressants, anti-anxiety-sedative agents, and anti-Parkinsonian agents).
3. A copy of the Social History which contains current psychosocial information specified in the "Guidelines for Social History" found in 471-000-234. The nursing facility may use its own social summary form as long as it contains the minimum information required for the Level II screening. In facilities with more than 100 beds, the Social History must be completed or countersigned by a certified social worker who is certified by the Department of Health and Human Services Regulation and Licensure.

12-007.03 Other Admission Requirements

12-007.03A Prior Authorization: Each admission must be separately prior authorized.

12-007.03B Admission Notification: At the time of admission or no later than 48 hours (two working days) after a client is admitted, the facility shall notify the local office that handles the client's case.

12-007.03C History and Physical: Before or at the time of admission to an NF, a physician* shall make a medical evaluation of each client's need for care in the NF and plan of rehabilitation, if applicable. Facility staff shall ensure that -

1. The client being admitted to the SNF/NF-licensed bed has had a physical examination within 48 hours (two working days) after admission unless an examination was performed within five days before admission;
2. The history and physical can be documented on Form DM-5 (see 471-000-221); Hospital history and physical; or any form used by the physician; and
3. Each medical evaluation at a minimum must include -
   a. Diagnoses;
   b. Summary of present medical findings;
   c. Medical history;
   d. Mental and physical functional capacity; and
   e. Prognosis.

*Note: In accordance with 42 CFR 483.40(f), the Department will allow all but the following required physician tasks in a nursing facility (including tasks that the regulations specify must be performed personally by the physician) to be satisfied when performed by a nurse practitioner or physician's assistant who is not an employee of the facility but who is working in collaboration with a physician according to Nebraska statute and designation of duties:

1. Initial certification;
2. Admission orders; and
3. Admission plan of care.

12-007.03D Physician's Initial Certification (Form DM-5 or Form MC-9-NF): The physician's certification on Form DM-5 or Form MC-9-NF (see 471-000-203) must be signed and dated within the following time frame:

1. For clients already eligible at the time of admission, Form DM-5 or Section III of Form MC-9-NF must be completed and signed by the physician;
2. Form must be signed by a physician (if a physician signature stamp is used, the physician shall initial the stamped signature). Physician's assistant or registered nurse signature or initials are not acceptable; and
3. Form MC-9NF may be maintained in the client's medical record in the facility or building where the resident resides or in the patient account file in the business office.

12-007.04 Admission Forms

12-007.04A Admision Forms DM-5 LTC or MC-9-NF: To obtain prior authorization of payment for a Medicaid-eligible client admitted to a nursing facility, NF staff shall complete the following steps within 15 days of the date of admission to the nursing facility or the date eligibility was determined:

1. Complete an admission Form MC-9-NF (see 471-000-203) as required by 471 NAC 12-007.03D;
2. Attach a copy of Form DM-5 (see 471-000-221) or physician's history and physical and a copy of Form HHS-OBRA1 (see 471-000-223); and
3. Submit all the information to the local office.

12-007.04B Admission Forms for Swing-Bed Facilities: To obtain prior authorization for payment for a client admitted to a swing bed, facility staff shall within 15 days of the date of admission to the swing bed -

1. Complete an admission Form MC-9NF as required by 471 NAC 12-007.03D;
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Complete Form DM-5LTC, "Long Term Care Evaluation;" and
4. Submit all the information to the local office.

See 471 NAC 12-009.08 for policy on swing-bed services.

12-007.05 Advance Directives: The facility shall comply with the regulations at 471 NAC 2-005 ff.

12-007.06 Resident Assessment: The nursing facility shall conduct an interdisciplinary assessment of every resident's functional capacity, regardless of payor source, using the most recent version of Form MC-75 (see 471-000-43). The facility shall submit one copy of each assessment to HHS F&S within 30 days of completion.

12-007.06A R.N. Assessment Coordinator: Each facility shall designate a registered nurse (R.N.) assessment coordinator(s). The facility shall inform HHS F&S of the name of the R.N. assessment coordinator(s) (including the designated areas, if a facility designates more than one coordinator) and shall promptly inform HHS F&S of any changes. The R.N. assessment coordinator shall coordinate each assessment with the appropriate participation of health professionals. Each individual who completes a portion of an assessment shall sign and certify as to the accuracy of that portion of the assessment. The R.N. assessment coordinator shall sign and certify the completion of the assessment.

12-007.06B Frequency of Assessments: An assessment must be completed -

1. Admission (Initial): Must be completed by 14th day of resident's stay;
2. Annual Reassessment: Must be completed within 12 months of most recent full assessment;
3. Significant change in status reassessment: Must be completed by the end of the 14th calendar day following determination that a significant change has occurred. A significant change is defined in 471 NAC 12-007.06D;
4. Quarterly Assessment: Must be completed no less frequently than once every three months.

12-007.06C Combinations of Records: The following forms are required as indicated for each assessment:

1. Initial Assessment: Basic Assessment Tracking (section AA) AB, AC, Full Assessment, Section S;
2. Annual Assessment: AA, Full Assessment, Section S;
3. Significant Change: AA, Full Assessment, Section S;
4. Quarterly Review: AA, Quarterly Review (RUGS II), Section S or AA, Full Assessment, Section S. If full assessment is used, enter "5" in field AA8a and "6" in field AA8b;
5. Short Stay (14 days or less): Discharge Tracking Form, Section S;
6. Discharge: Discharge Tracking Form, Section S;
7. Re-entry (from a Temporary absence): Re-entry tracking form, Section S.

12-007.06D Definition of Significant Change: A "significant change" is:

1. Deterioration in two or more activities of daily living, communication, and/or cognitive abilities that appear PERMANENT. For example, simultaneous functional and cognitive decline often experienced by residents with chronic degenerative illnesses such as Alzheimer's disease or pronounced functional changes following a stroke;
2. Loss of ability to freely ambulate or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush, or comb. These losses must be PERMANENT and not attributable to identifiable, reversible causes such as drug toxicity from introducing a new medication, or an episode of acute illness such as influenza;
3. Deterioration in behavior, mood, and/or relationships that has not been reversed by current staff interventions;
4. Deterioration in a resident's health status, where this change -
   a. Places the resident's life in danger, e.g., stroke, heart condition, or diagnosis of metastatic cancer;
   b. Is associated with a serious clinical complication, e.g., initial development of a stage III or stage IV pressure ulcer, the initial onset of nonrelieved delirium, or recurrent loss of consciousness; or
   c. Is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time, e.g., Alzheimer's disease or diabetes;
5. A serious clinical complication;
6. A new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time;
7. Onset of a significant weight loss (five percent in last 30 days or ten percent in last 180 days); or
8. A marked and sudden improvement in the resident's status, for example, a comatose resident regaining consciousness.

A "significant change" is defined as a major change in the resident's status that -

1. Is not self-limiting. A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions;
2. Impacts on more than one area of the resident's health status; and
3. Requires interdisciplinary review or revision of the care plan.

A significant change assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement.

Concepts associated with significant change are "major" or "appears to be permanent" but a change does not need to be both major and permanent.

The NF shall document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. The NF shall complete a full comprehensive assessment as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days of determining a significant change has occurred.

12-007.06D1 Other Changes: The facility need not assess the resident if declines in a resident's physical, mental, or psychosocial well-being are attributable to –

1. Discrete and easily reversible cause(s) documented in the resident's record and for which facility staff can initiate corrective action. For example, an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level;
2. Short-term acute illness, such as a mild fever secondary to a cold from which facility staff expect full recovery of the resident's pre-morbid functional abilities and health status; or
3. Well established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease.

12-007.06E Quarterly Review: The nursing facility shall review the following elements for all residents quarterly, document the results, and revise the plan of care, if indicated. The quarterly assessment shall be completed using the most recent version of Form MC-75Q (see 471-000-44). The facility shall submit one copy of each quarterly assessment to the Department within 30 days of completion within 30 days of completion.

Key Mandated MDS Items for Quarterly Assessment:

Section A: Identification and Background Information
- Item 1 - Resident Name
- Item 2 - Room Number
- Item 3a - Assessment Reference Data
- Item 4A - Date of Reentry
- Item 6 - Medical Record Number

Section B: Cognitive Patterns
- Item 1 - Comatose
- Item 2 - Memory
- Item 4 - Cognitive Skills for Daily Decision-making
- Item 5 - Indicators of Delirium - Periodic Disordered Thinking/ Awareness

Section C: Communication/Hearing Patterns
- Item 4 - Making Self Understood
- Item 6 - Ability to Understand Others

Section E: Mood and Behavior Patterns
- Item 1 - Indicators of Depression, Anxiety, Sad Mood
- Item 2 - Mood Persistence
- Item 4 - Behavioral Symptoms

Section G: Physical Functioning and Structural Problems
- Item 1 - ADL Self-Performance
- Item 2 - Bathing
- Item 4 - Functional Limitation in Range of Motion
- Items 6a, b, and f - Modes of Transfer

Section H: Continence in Last 14 Days
- Item 1 (Continence Self-Control Categories
- Item 2d and e - Bowel Elimination Pattern
- Items 3a, b, c, d i and J - Appliances and Programs

Section I: Disease Diagnoses
- Items 2j and M - Infections
- Item 3 - Other Current Diagnosis and ICD-10 Codes
  (Note only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring or risk of death.)

Section J: Health Conditions
- Item 1c, i, and p - Problem Conditions
- Item 2 - Pain Symptoms
- Item 4 - Accidents
- Item 5 - Stability of Conditions

Section K: Oral/Nutritional Status
- Item 3 - Weight Change
- Item 5b, h, and i - Nutritional Approaches

Section M: Skin Condition
- Item 1 – Ulcers
- Item 2 - Type of Ulcer

Section N: Activity Pursuit Patterns
- Item 1 - Time Awake
- Item 2 - Average Time Involved in Activities

Section O: Medications
- Item 1 - Number of Medications
- Item 4 - Days Received the Following Medications

Section P: Special Treatment and Procedures
- Item 1 - Devices and Restraints

Section Q: Discharge Potential
- Item 2 - Overall Change in Care Needs

Section R: Assessment/Discharge Information
- Item 2 - Signatures of Persons Completing the Assessment

Section S: State Specific Supplement-NE

12-007.06F Use of Independent Assessors: If the Department determines, under a survey by the Department of Health and Human Services Regulation and Licensure or otherwise, that assessments are not being completed or that there has been a knowing and willful false certification of information under this section, the Department may require for a period of time specified by the Department that resident assessments under this section be conducted and certified by individual(s) who are independent of the facility and who are approved by the Department. The facility is responsible for the reasonable payment of the individuals completing the assessment. The cost may be included on Form FA-66, "Long Term Care Cost Report."

12-007.07 Comprehensive Care Plan: The facility shall develop a comprehensive care plan for each client that includes measurable objectives and timetables to meet a client's medical, nursing, and psychosocial needs that are identified in a comprehensive assessment (Form MC-75 – see 471-000-43). The plan must be -

1. Developed within seven days after completion of the comprehensive assessment;
2. Prepared by an interdisciplinary team; and
3. Periodically reviewed and revised by a team of qualified persons after each assessment, or at least quarterly.

The plan must include recommendations of the PASP Level II evaluation, if applicable. Refer to 471 NAC 12-004.13C.

12-007.08 Annual Physical Examination: The Nebraska Medical Assistance Program (also known as Medicaid) requires that all nursing facility residents have an annual physical examination. The physician*, based on his/her authority to prescribe continued treatment, determines the extent of the examination for NMAP clients based on medical necessity. For the annual physical exam, a CBC and urinalysis will not be considered "routine" and will be reimbursed based on the physician's orders. The results of the examination must be recorded in the client's medical record.

*Note: In accordance with 42 CFR 483.40(f), the Department will allow all but the following required physician tasks in a nursing facility (including tasks that the regulations specify must be performed personally by the physician) to be satisfied when performed by a nurse practitioner or physician's assistant who is not an employee of the facility but who is working in collaboration with a physician according to Nebraska statute and designation of duties:

1. Initial certification;
2. Admission orders; and
3. Admission plan of care.

12-007.08A Billing for the Annual Physical Examination: If the annual physical examination is performed solely to meet the Medicaid requirement, the physician shall submit the appropriate professional claim (see Claim Submission Table at 471-000-49) to the Department. If the physical examination is performed for diagnosis and/or treatment of a specific symptom, illness, or injury and the client has Medicare or other third party coverage, the physician shall submit the claim through the usual Medicare or other third party process.

12-007.09 Physician Services: The physician* must see the client whenever necessary, but at least once every 30 days for the first 90 days following admission, and at least once every 60 days thereafter.

At the time of each visit, the physician shall -

1. Review the client's total program of care, including medications and treatments;
2. Write, sign, and date progress notes at each visit; and
3. Sign all orders.

*Note: In accordance with 42 CFR 483.40(f), the Department will allow all but the following required physician tasks in a nursing facility (including tasks that the regulations specify must be performed personally by the physician) to be satisfied when performed by a nurse practitioner or physician's assistant who is not an employee of the facility but who is working in collaboration with a physician according to Nebraska statute and designation of duties:

1. Initial certification;
2. Admission orders; and
3. Admission plan of care.

12-007.10 Medical Care/Services: The facility shall ensure that admitted Medicaid clients receive appropriate medical care/services. If the appropriate medical care/service cannot be provided using facility staff, the facility shall arrange for the care/service to be provided.

12-007.11 Therapy Services: For medically necessary therapy services which are ordered by the physician, see -

1. 471 NAC 14-000, Occupational Therapy Services;
2. 471 NAC 17-000, Physical Therapy Services;
3. 471 NAC 22-000, Respiratory Therapy Services; and
4. 471 NAC 23-000, Speech Pathology and Audiology Services.

12-007.12 Dental Care: Facilities shall provide dental examinations as needed. NMAP covers one routine dental exam per year for clients age 21 and older. Emergency exams are covered as needed by NMAP to diagnose dental pain. For clients age 20 and younger NMAP covers a dental exam every six months or more often if medically necessary. Questions should be referred to the Medicaid Division dental staff. (See 471 NAC 6-000. for dental services.)

12-007.13 Freedom of Choice: Each facility shall ensure that any client may exercise his/her freedom of choice in obtaining NMAP-covered services from any provider qualified to perform the services (see 471 NAC 1-004.02). Clients participating in Medicaid managed care must comply with the conditions of their managed care plan.

12-007.14 Room and Bed Assignments: Facility staff shall maintain a permanent record of the client's room and bed assignments. This record must show the dates and reasons for all changes and be maintained in the nurses' notes in the health chart/medical record.

12-007.15 Residents' Rights: The facility shall protect and promote the rights of each resident as defined in 42 CFR 483.10.

When the resident is unable to manage his/her own personal funds, and there is not a guardian or responsible family member, the facility shall arrange for, or manage, the personal funds as specified in 42 CFR 483.10(c)(1) thru (8).

12-007.16 Bed-Holding Policies for Hospital and Therapeutic Leave: The facility shall develop policies as defined in 42 CFR 483.12(b).

12-007.16A Initial Notice of Bed-Holding Policies: The facility shall provide written information to the client and a family member or legal representative that specifies -

1. The duration of the bed-hold policy during which the client is permitted to return and resume residence in the facility; and
2. The facility's policies regarding bed-hold periods which must be consistent with 42 CFR 483.12(b).

12-007.16B Notice Upon Transfer: At the time of transfer, the facility shall provide written notice to the client and a family member or legal representative which specifies the duration of the bed-hold policy.

12-007.16C Permitting the Client to Return to the Facility: The facility shall establish and follow a written policy under which a client whose leave exceeds the bed-hold period is re-admitted to the facility immediately upon availability of a bed if the client -

1. Requires the services provided by the facility; and
2. Is eligible for Medicaid nursing facility services.

12-007.17 Facility-to-Facility Transfer: To transfer any Medicaid client from one facility to another, the transferring facility shall -

1. Obtain physician's written order for transfer;
2. Obtain written consent from the client, his/her family, and/or guardian;
3. Notify the local office that handles the client's case in writing, stating -
   a. The reason for transfer;
   b. The name of facility to which the client is being transferred; and
   c. The date of transfer;
4. Transfer the following to the receiving facility:
   a. Necessary medical/social/PASP information (including the ID screen and evaluation packet);
   b. Any non-standard wheelchair and wheelchair accessories/options/components, including power operated vehicles;
   c. Any Augmentative Communication Devices with Related Equipment and Software;

d. Supports (e.g. trusses and compression stockings with related components); and
e. Custom fitted and/or custom fabricated items.

Note: These above items specifically purchased for and used by the client shall be transferred with the client.

5. Document transfer information in the client's record and discharge summary.

The admitting facility shall obtain a new prior authorization for the current admission and follow admission requirements in 471 NAC 12-007.02. A nursing facility to nursing facility transfer does not require completion of a new Form HHS-OBRA1 (see 471-000-223).

12-007.18 Discharges: At the time of or no later than 48 hours (two working days) after a client is discharged or expires, the facility shall notify the local office that handles the client's case of -

1. Date of discharge and the place to which the client was discharged; or
2. Date of death.

12-007.19 Discharge Planning: Each nursing facility shall maintain written discharge planning procedures for all Medicaid clients that describe -

1. Which staff member of the facility has operational responsibility for discharge planning;
2. The manner in, and methods by, which the staff member will function, including authority and relationship with the facility's staff;
3. The time period in which each client's need for discharge planning will be determined (which period may not be later than seven days after the day of admission);
4. The maximum time period after which the interdisciplinary team reevaluates each client's discharge plan;
5. The resources available to the facility, the client, and the attending physician to assist in developing and implementing individual discharge plans; and
6. The provisions for periodic review and reevaluation of the facility's discharge planning program.

Before a client's discharge or deinstitutionalization, the facility staff shall document in the medical record the actual implementation date of the discharge plan.

12-007.19A Inappropriate Level of Care: If it is determined that the client's present level of care is inappropriate -

1. The present facility shall provide services to meet the needs of the client and shall refer to appropriate agencies for services until an appropriate living situation is available;
2. The facility shall document that other alternatives were explored and the responses;
3. The facility and the local office worker shall make documentation of active exploration for appropriate living situations available to the medical review team;
4. The facility shall notify the local office worker prior to expiration of the time frame; and

5. The facility shall work cooperatively with the PASARRP referral process.

12-007.19B At the Time of Discharge: At the time of the client's discharge, the facility shall:

1. Provide any information about the discharged client that will ensure the optimal continuity of care to those persons responsible for the individual's post-discharge care.
2. Include current information on diagnosis, prior treatment, rehabilitation potential, physician advice concerning immediate care, and pertinent social information.
3. Discharge the following items specifically purchased for and used by the client with the client:

    a. Any non-standard wheelchair and wheelchair accessories, options, and components, including power operated vehicles;
    b. Any augmentative communication devices with related equipment and software;
    c. Supports (e.g. trusses and compression stockings with related components); and
    d. Custom fitted and/or custom fabricated items.

12-008 Appeals of Discharges, Transfers, and PASP Determinations: A resident of a skilled nursing facility (SNF) or a nursing facility (NF) who receives a notice from the SNF or NF of the intent to discharge or transfer the resident may appeal to the Department of Health and Human Services Finance and Support for a hearing on this notice. The appeal and hearing must be conducted under 465 NAC 2-001.02 and 6-000 ff.

An individual who is adversely affected by any PASP determination may appeal to the Department of Health and Human Services Finance and Support for a hearing on the decision.

The individual or legal representative will be instructed to contact HHS/contractor for information on appeals and to forward a written request for an appeal to the Department of Health and Human Services Finance and Support within 90 days of the date of the PASP determination notice. The appeal and hearing must be conducted under 465 NAC 2-001.02 and 2-006 ff. Also see 471 NAC 12-004.15.

12-009 Medicaid Payment Restrictions for NF: NMAP shall pay for a nursing facility service only when prior authorized (see 471 NAC 12-007.01).

12-009.01 Initial Certification: HHS F&S shall approve payment to a facility for services rendered to an eligible client beginning on the latest date of –

1. The client is admitted to the facility;
2. The client's eligibility is effective, if later than the admission date; or
3. the date of ID screen (Form HHS-OBRA1) or the effective date on Form HHS-OBRA5, "Notice and Finding (see 471-000-227)."

For clients assessed by SCO, the first possible day of payment is the date of referral to SCO provided that the client meets NF level of care criteria. For persons referred to SCO prior to Medicaid eligibility determination, see 471 NAC 12-005.04D2 and D3.

12-009.02 Death on Day of Admission: If a client is admitted to a facility and dies before midnight on the same day, the Department allows payment for one day of care (see 471 NAC 12-011.06B).

12-009.03 Inappropriate for NF Care: For those clients who, at the time of Medical Review determination, no longer meet NF criteria (471 NAC 12-003) for nursing facility services, the Medical Review shall limit Medicaid payment for up to a maximum of 30 days, beginning with the date the Medical Review determines that nursing facility care is inappropriate.

Time-limited authorizations exceeding 30 days may be made based on the client's potential for discharge as determined by the Medical Review.

12-009.04 Effect of PASP (MI/MR/RC): Medicaid payment is available for nursing facility services provided to Medicaid-eligible clients who, as a result of PASP -

1. Were found to require the nursing facility level of care; or
2. Were found inappropriate for nursing facility care but through the 30-month choice have elected to remain in a nursing facility.

When a PASP is not performed before admission, Medicaid payment for nursing facility services is available only for services provided after the PASP is completed.

12-009.05 Items Included in Per Diem Rates: The following items are included in the per diem rate:

1. Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services and activity program as required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are -
   a. All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; hand-feeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
   b. Maintenance Therapy: facility staff shall aid the resident as necessary, under the resident's therapy program, with programs intended to maintain the function(s) being restored including but not limited to augmentative communication devices with related equipment and software;
   c. Items which are furnished routinely and relatively uniformly to all patients, such as patient gowns, linens, water pitchers, basins, bedpans, etc.;
   d. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, band-aids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, moisturing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, sanitary napkins and related supplies, etc.), etc.;
   e. Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, other durable medical equipment and their maintenance, etc.;
   f. Nutritional supplements and supplies used for oral, parenteral or enteral feeding;
   g. Laundry services, including personal clothing; and
   h. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.
2. Injections: The patient's physician shall prescribe all injections. Payment is not authorized for the administration of injections, since giving injections is considered a part of routine nursing care and covered by the long term care facility's reimbursement. Payment is authorized to the drug provider for drugs used in approved injections. Syringes and needles are necessary medical supplies and are included in the per diem rate.

3. Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility shall provide transportation to client services that are reimbursed by Medicaid (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.
4. Contracted Services: The nursing facility shall contract for services not readily available in the facility -
   a. If the service is provided by an independent licensed provider who is enrolled in Medicaid (i.e., physical therapist or physician) the provider shall submit a separate claim (Form HCFA-1500) for each person served; and
   b. If the service is provided by a certified provider of medical care (i.e., QMRP assessment or respiratory therapist) the nursing facility is responsible for payment to the provider. This expense is an allowable cost.
5. Single Room Accommodations: Medicaid residents should be afforded equal opportunity to remain in or utilize single-room accommodations. Any facility that prohibits or requires an additional charge for Medicaid utilization of single-room accommodations must make an appropriate adjustment on its cost report to remove the additional cost of single-room accommodations. To make the adjustment, 50% of the facility's fixed cost per diem multiplied by the number of supplemented Medicaid days of care must be subtracted from the facility's reported cost. The facility must not make an additional charge for a therapeutically required single room nor is the facility required to make a cost report adjustment for this type of room. Each facility must have a written policy on single-room accommodations for all payers.

12-009.06 Items Not Included in Per Diem Rates

12-009.06A Payments to Nursing Facility Provider SEPARATE from Per Diem Rates: Items for which payment may be made to Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter.

1. Any non-standard wheelchairs and wheelchair accessories, options, and components, including power-operated vehicles needed for the client's permanent and full time use (see 471 NAC 7). Standard wheelchairs are considered necessary equipment in an NF to provide care and part of the per diem.
2. Air fluidized bed units and low air loss bed units (see 471 NAC 7); and
3. Negative Pressure Wound Therapy, (See 471 NAC 7).

12-009.06B Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16);
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses (see 471 NAC 24), hearing aids (see 471 NAC 8), etc.;
3. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7;
4. Prostheses (e.g. breast, eye, lower and upper limb) as defined in 471 NAC 7; and
5. Ambulance services (See 471 NAC 4).

12-009.06C May Be Charged to Resident's Funds: Items that may be charged to residents' funds and are not considered as part of the facility's Medicaid per diem are -

1. Telephone;
2. Television/radio for personal use (except cable service);
3. Personal comfort items, including smoking materials, notions, and novelties, and confections;
4. Cosmetic and grooming items and services that are specifically requested by the client and are in excess of the basic grooming items provided by the facility;
5. Personal clothing;
6. Personal reading matter;
7. Gifts purchased on behalf of the client;
8. Flowers and plants;
9. Social events and entertainment offered outside the scope of the activities program required by certification;
10. Non-covered special care services such as privately hired nurses or aides specifically requested by the client and/or family;
11. Specially prepared or alternative food requested instead of the food generally prepared by the facility (as required by certification); or
12. Single room, except when therapeutically required (for example, isolation for infection control).

12-009.06D 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 Bed-holding: 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 bed-holding 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 bed-holding is limited to reimbursement for 15 days per hospitalization. Hospital bed-holding 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 bed-holding is limited to reimbursement for 18 days per calendar year. Bed-holding 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;
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 bed-hold 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 bed-holding 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 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 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.

8. Frequent catheterization or indwelling catheter care: urinary, bile ducts, chest, etc., or in combination with other skilled services;
9. Application of aseptic dressings and treatments (i.e., wound, tracheostomy care);
10. Nasopharyngeal aspiration and throat suctioning;
11. Levine tube and gastrostomy feedings; and
12. Decubitus ulcers - Stage III or IV.

The requirements of PASP, resident assessment (MDS) and SCO preadmission screening do not apply to swing beds.

12-009.08A Standards for Participation: To participate in NMAP as a provider of swing-bed services, the hospital must be certified as a Medicare swing-bed facility by the Nebraska Department of Health and Human Services Regulation and Licensure.

12-009.08B Provider Agreement: To be approved by HHS F&S as a swing-bed provider, the hospital shall complete and sign Form MC-20 (see 471-000-91). The agreement must be submitted to and approved by HHS F&S. If the hospital has an approved agreement with HHS F&S, it is not necessary to complete another Form MC-20 to provide swing-bed services.

12-009.08C Prior Authorization: See 471 NAC 12-007.04B.

12-009.08D Payment: NMAP pays for swing-bed services at the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

To bill NMAP for swing-bed services, the hospital shall submit Form MC-4, "Long Term Care Facility Turnaround Billing Document" (see 471-000-82) or submit electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837). If Medicare is covering the swing-bed services, the facility shall bill according to Medicare instructions.

When the client no longer requires a skilled level of care, NMAP may authorize payment for up to five working days of care, when necessity to facilitate transfer to the appropriate level of care.

12-009.08E Ancillary Services: If the hospital bills for swing bed services on Form MC-4 or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837), the hospital shall bill as follows for ancillary services for swing-bed patients who are eligible for Medicaid only. If Medicare is covering the swing-bed services, the facility shall not bill NMAP for ancillary services.

Laboratory, radiology, respiratory therapy, physical therapy, occupational therapy, and speech pathology and audiology services must be billed on Form CMS-1450 or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837) as outpatient services. These payment must be reported on the Medicare cost report as outpatient revenues.

12-009.08F Therapy: Certain services, defined as "waiver claims" are an exception to the requirement of 471 NAC 3-004.03 regarding third party liability. Nursing facility services are included in the definition of "waiver claims." Providers may submit these claims to Medicaid before filing for third party liability (TPL); NMAP pays the nursing facility claims and COB staff initiate recovery activities for any third party resource. This does not prohibit the provider from billing the third party resource (TPR) before billing Medicaid.

12-010 (Reserved)

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.

Nursing Facility Quality Assurance Fund means the fund created in Neb. Rev. Stat. § 68-1926 as the repository for provider tax payments remitted by nursing facilities and skilled nursing facilities.

Quality Assurance Assessment means the assessment imposed under the Nursing Facility Quality Assurance Assessment Act in Neb. Rev. Stat. § 68-1917.

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, adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).

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, 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) adjusted to include the Nursing Facility Quality Assurance Assessment component (see 471 NAC 12-011.08D.

Revisit Fees means fees charged to health care facilities by the Secretary of Health and Human Services to cover the costs incurred under 'Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management' for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys.

Urban means Douglas, Lancaster, Sarpy, and Washington Counties.

Waivered Facility means facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of waivered days exceeds 90 calendar days at any time during the reporting period.

Weighted Resident Days means a facility's inpatient days, as adjusted for the acuity level of the residents in that facility.

Other definitions which apply in this section are included in Nebraska Department of Health and Human Services Division of Public Health's regulations in Title 175, Chapter 12, Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities and appropriate federal regulations governing Title XIX and Title XVIII.

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of the beginning of each applicable cost report period) are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (Medicaid) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

Except for IHS nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 471 NAC 12-011.08B) will not file a cost report. The rate paid will be based on the average base rate components, effective July 1 of the rate period, of all other providers in the same care classification, following the initial desk audits.

12-011.04 Allowable Costs: The following items are allowable costs under Medicaid.

12-011.04A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

1. Meet the definition and requirements for a Nursing Facility of Title XIX of the Social Security Act, Section 1919;
2. Comply with the standards prescribed by the Secretary of the federal Health and Human Services (HHS) for nursing facilities in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health, the state agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.

12-011.04B Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:

1. General nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; hand-feeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
2. Maintenance Therapy: facility staff must aid the client as necessary, under the client's therapy program, with programs intended to maintain the function(s) being restored, including but not limited to augmentative communication devices with related equipment and software;
3. Items which are furnished routinely and relatively uniformly to all clients, such as patient gowns, water pitchers, basins, bedpans, etc.;
4. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, band-aids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.);
5. Items which are used by individual clients which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc. not listed in 12-009.05 and 12-009.06;
6. Nutritional supplements and supplies used for oral, parenteral or enteral feeding;
7. Laundry services, including personal clothing;
8. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service;
9. Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance;
10. Injections and supplies: including syringes and needles, but excluding the cost of the drug(s) not listed in 12-009.05 and 12-009.06;

12-011.04C Ancillary Services: Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as "routine services." The facility must contract for ancillary services not readily available in the facility.

If ancillary services are provided by a licensed provider or another licensed facility, e.g., physician, dentist, physical/occupational/speech therapists, etc., the ancillary service provider must submit a separate claim for each client served.

Allowable costs paid to Physical, Occupational and Speech Therapists are limited to reasonable amounts paid for general consulting services plus reasonable transportation costs not covered through direct billing. General consulting services are not client specific, but instead, are staff related. These services include staff education, in-services and seminars.

Respiratory therapy is an allowable cost.

12-011.04D Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16). Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses (see 471 NAC 24), hearing aids (see 471 NAC 8), etc.;
3. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7;
4. Prostheses (breast, eye, lower and upper limb) as defined in 471 NAC 7;
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4.
    a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, Medicaid will not make payment for ambulance service.
    b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the Nursing Facility).

12-011.04E Payments to Nursing Facility Provider SEPARATE from Per Diem Rates: Items for which payment may be made to Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item outlined in the appropriate Medicaid provider chapter.

1. Any Non-standard wheelchairs and wheelchair accessories, options, and components, including power-operated vehicles needed for the client's permanent and full time use (see 471 NAC 7);
2. Air fluidized bed units and low air loss bed units (see 471 NAC 7); and
3. Negative Pressure Wound Therapy, See 471 NAC 7).

12-011.05 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing per local area telephone directory is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of facility. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians, therapists or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
12. Return on equity;

13. Carry-over of costs "lost" due to any limitation in this system;
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts; and
15. Revisit fees.

12-011.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination.

12-011.06A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

12-011.06B Total Inpatient Days: In computing the provider's allowable per diem rates, total inpatient days are used. An inpatient day is:

1. A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or
2. A day on which the bed is held for hospital leave or therapeutic home visits.

Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year.

Medicaid inpatient days are days for which claims or electronic Standard Health Care Claim: Institutional transaction (ASC X12N 837) from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are considered Medicaid inpatient days in compiling inpatient days. A facility may not impose charges that exceed the payment rate established under 471 NAC 12-011 for these days.

12-011.06C Start-Up Costs: All new providers entering NMAP must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

12-011.06D Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions. (Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply); and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

12-011.06E Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 12-011.06H and J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the federal Department of Health and Human Services (HHS), or their designated representatives.

12-011.06F Home Office Costs - Chain Operations: A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating providers. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the cost report. Costs allocated under HIM-15, Section 2150.3.B, are limited to direct patient care services provided at the facility, and must be included in the applicable Cost Category. Costs allocated under HIM-15, Sections 2150.3C and 2150.3D, are included in the Administration Cost Category. The NMAP does not distinguish between capital related and non-capital related interest expense and interest income (see HIM-15, Section 2150.3E and 2150.3F).

12-011.06G Interest Expense: Interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for nursing facility care. This limitation does not apply to government owned facilities.

12-011.06H Recognition of Fixed Cost Basis: The fixed cost basis for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Division of Public Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 12-011.09E, Recapture of Depreciation, will apply to this part.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

12-011.06J Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 12-011, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department for the purposes of rate setting are the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Division of Public Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Division of Public Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Division of Public Health. The added costs incurred before the date the late amendment or report is filed will not be recognized retroactively for rate setting.

12-011.06K Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6). See Appendix 471-000-111 for Administrator compensation maximums.

For future cost report periods, administrator compensation maximums will be adjusted annually based on inflation factors published in HIM 15, Section 905.6 and will not be specified in the regulations. Once calculated, these maximums will be available for review from the Department and published in Appendix 471-000-111.

All compensation received by an administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey".

12-011.06L Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing and Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing and Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing and Support Services components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

12-011.06M Direct Nursing Costs: Direct nursing costs include cost report lines 94 through 103. The following descriptions cover some of these costs:

1. Salaries of the Director of Nursing and other licensed health professionals (RNs & LPNs) who are practicing within the scope of their license;
2. Salaries of other licensed or certified individuals providing routine nursing or routine nursing-related services to residents; and unlicensed, assistive personnel providing nursing-related support for direct nursing care to residents. Nursing-related support includes, but is not limited to: bathing, dressing, transfer, dining assistance, bed mobility, walking, range of motion, bed making, filling water pitchers, personal hygiene, administration of medications and other activities of daily living; or training/instruction of residents in these services;
3. Salaries directly related to:
   a. Nursing staff scheduling;
   b. Preparation of resident assessments, development of care plans, and other required documentation;
   c. Instruction of and attendance at nursing inservice training;
   d. Medical records, including record transcription, file thinning, setup of initial files, and other medical record services; and
   e. Quality assurance services;
4. The documented nursing portion of multi-purpose and/or universal workers' salaries:
   a. A multi-purpose employee has nursing and non-nursing job duties. For example, medical records (Nursing) and payroll (Administration).
   b. Universal workers are employees who perform multiple tasks for residents, usually in a distinct unit, pod, or neighborhood. The tasks performed by the universal workers have traditionally been divided between employees of separate departments. Services provided by universal workers may include two or more of the following functions:
      (1) Nursing;
      (2) Activities;
      (3) Laundry;
      (4) Housekeeping; and
      (5) Dietary;
   c. Multi-purpose and/or universal workers who perform services in more than one functional area must identify their time using one of the following approved methods:
      (1) Maintenance of daily continuous timesheets – The daily timesheet must document, for each day, the person's start time, stop time, total hours worked, and the actual time worked in each functional area;
      (2) Maintenance of time studies as defined in Medicare HIM-15 (section 2313.2E);
      (3) Other methods as pre-approved by the Department;
5. Payroll taxes and employee benefits related to the salaries outlined above. Employee benefits DO NOT include help wanted advertising, pre-employment physicals, background checks, etc;
6. Consulting Registered Nurse;

7. Salary, payroll taxes and employee benefits of home office nursing personnel while performing facility-specific direct care nursing services, if the costs are allocated according to Medicare HIM-15, Section 2150.3B. Related overhead costs, including, but not limited to, travel time, lodging, meals, etc., cannot be reported as Direct Nursing costs. Report overhead costs in the Administration cost category; and
8. Purchased Services – Direct Care (pool nurse labor). Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply.

12-011.06N Plant Related Costs: Plant related costs include cost report lines 129 through 163. The following descriptions cover some of these costs.

1. Costs of routine maintenance services performed by an outside vendor rather than by the provider's maintenance staff. Examples include lawn care, alarm maintenance/monitoring, pest control and snow removal;
2. Costs of incidental supplies and materials used by maintenance personnel and/or maintenance contractors in maintaining or repairing the building, grounds and equipment (excluding business equipment). Examples include paintbrushes, tools, hardware items (screws, nails, etc.), fertilizer, lumber for small projects and electrical & plumbing supplies. Aviary and other pet supply costs are to be reported in the Activities cost category;
3. Repairs and maintenance applicable to the building, grounds, equipment (excluding business equipment) and vehicles. Report maintenance and repair expenses applicable to business equipment (e.g. computers, copiers, fax machines, telephones, etc.) as an Administration expense.

12-011.06O Equipment Lease and Maintenance Agreements: Costs of equipment lease or maintenance agreements that include or are tied to usage or supplies must be reported in the operating cost category that most closely relates to the equipment.

1. Example 1: The provider has a 5-year copier lease. Monthly lease payments are based on the number of copies made. These costs must be reported in the Administration cost category.
2. Example 2: The provider has a maintenance agreement for a dishwasher. A condition of the agreement requires a minimum monthly purchase of dishwasher supplies. These costs must be reported in the Dietary cost category.

12-011.06P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

12-011.06Q Nursing Facility Quality Assessments: Except for providers that are exempt under Neb. Rev. Stat. § 68-1918, each nursing facility or skilled nursing facility licensed under the Health Care Facility Licensure Act shall pay a quality assurance assessment based on total resident days, including bedhold days, less Medicare days. The cost of the assessment will be reported on the cost report when paid. The nursing facility quality assessment is an allowable cost addressed through the Nursing Facility Quality Assessment Component.

12-011.07 (Reserved)

12-011.08 Rate Determination: The Department determines rates for facilities under the following cost-based prospective methodology.

12-011.08A Rate Period: The Rate Period is defined as July 1through June 30. Rates paid during the Rate Period are determined (see 471 NAC 12-011.08D) from cost reports submitted for the Report Period ending June 30, two years prior to the end of the Rate Period. For example, cost reports submitted for the Report Period ending June 30, 2009 determine rates for the Rate Period July 1, 2010 through June 30, 2011.

12-011.08B Report Period: Each facility must file a cost report each year for the reporting period of July 1 through June 30.

12-011.08C Care Classifications: A portion of each individual facility's rate may be based on the urban or non-urban location of the facility.

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department determines facility-specific prospective per diem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums are computed using audited data following the initial desk audits and are not revised based on subsequent changes to the data. Only cost reports with a full year's data are used in the computation. Cost reports from providers entering or leaving the Medicaid during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of four components:

1. The Direct Nursing Component adjusted by the inflation factor;
2. The Support Services Component adjusted by the inflation factor;
3. The Fixed Cost Component; and
4. The Nursing Facility Quality Assessment Component.

The Direct Nursing Component and the Support Services Component are subject to maximum per diem payments based on Median/Maximum computations.

Median: For each Care Classification, the median for the Direct Nursing Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding waivered, and/or facilities with partial or initial/final full year cost reports. For each Care Classification, the median for the Support Services Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding hospital based, waivered, and/or facilities with partial or initial/final full year cost reports.

The Department will reduce the Direct Nursing Component median by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

Maximum: The maximum per diem is computed as 125% of the median Direct Nursing Component, and 115% of the median Support Services Component. The Department will reduce the Direct Nursing Component maximum by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

The Fixed Cost Component is subject to a maximum per diem of $27.00, excluding personal property and real estate taxes.

Each facility's base prospective rate is computed as the sum of the facility-specific Direct Nursing and Support Services components adjusted by the inflation factor and the Fixed Cost Component, subject to the rate limitations and component maximums of this system. The Direct Nursing, Support Services, and Fixed Cost components are expressed in per diem amounts.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the allowable direct nursing costs (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Rate determination for the Direct Nursing Component for an individual facility is computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.08D2 Support Services Component: This component of the prospective rate is computed by dividing the allowable costs for support services (lines 34, 63, 78, 93, 104 through 127, 163, 184, and 185 from the FA-66); Resident Transportation - Medical from the Ancillary Cost Center (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (lines 203 through 210 from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Rate determination for the Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, or a maximum per diem of $27.00 excluding personal property and real estate taxes.

12-011.08D4 Nursing Facility Quality Assessment Component: The Nursing Facility Quality Assessment component shall not be subject to any cost limitation or revenue offset.

The quality assessment component rate will be determined by calculating the "anticipated tax payments" during the rate period and then dividing the total anticipated tax payments by "total anticipated nursing facility/skilled nursing facility patient days", including bed-hold days and Medicare patient days.

For the first rate period, during which this section becomes operative, the "anticipated tax payments" will be determined by annualizing total facility patient days, including bed-hold days, less Medicare days from the time period beginning the January 1 and ending the June 30 preceding the beginning of the rate period. "Total anticipated nursing facility/skilled nursing facility patient days" will be determined by annualizing total facility patient days, including bed-hold days and Medicare days, from the time period beginning the January 1 and ending the June 30 preceding the beginning of the rate period. Nursing facilities will not be assessed a tax on any patient days prior to July 1, 2011.

For each subsequent rate period, total facility patient days, including bed-hold days, less Medicare days, for the four most recent calendar quarters available at the time rates are determined will be used to calculate the "anticipated tax payments". Total facility patient days, including bed-hold days and Medicare days, for the same four calendar quarters will be used to calculate the "anticipated nursing facility/skilled nursing facility patient days".

12-011.08D5 Inflation Factor: The inflation factor is determined from spending projections using:

1. Audited cost and census data following the initial desk audits;
2. Budget directives from the Nebraska Legislature; and
3. Funding generated by the Nursing Facility Quality Assurance Assessment.

Once calculated, rates are available for review from the Department.

12-011.08D6 Durable Medical Equipment (DME) Rate Add-On: Effective August 1, 2013, nursing facilities are responsible for costs of certain durable medical equipment. To account for these increased costs on prospective rates only:

1. For the rate period August 1, 2013 through June 30, 2014, prospective rates will be increased by $.90/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by $.90/day.
3. For the rate period July 1, 2015 through June 30, 2016, prospective rates will be increased by $.08/day.
4. For rate periods after June 30, 2016, prospective rates will not be increased by a DME rate add-on.

The DME rate add-on does not apply to Levels of Care 101-105.

Retroactive rate settlements computed according to 471 NAC 12-011.08H1 will not include a DME rate add-on as actual DME costs will be included in the reported Support Services – Other Nursing costs. To account for these increased Support Services costs on retroactive rate settlements only:

1. For the rate period August 1, 2013 through June 30, 2014, the Support Services Maximum will be increased by $.90/day.
2. For the rate period July 1, 2014 through June 30, 2015, the Support Services Maximum will be increased by $.90/day.
3. For the rate period July 1, 2015 through June 30, 2016, the Support Services Maximum will be increased by $.08/day.

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, 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 bed-hold days. The payment rate for Levels of Care 101, 102, 103, 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), adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid 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.

12-011.08H Rates for New Providers:

Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department. A new provider is an individual or entity which obtains their initial, facility-specific provider agreement to operate an existing nursing facility due to a change in ownership, or to operate a nursing facility not previously enrolled in Medicaid. For purposes of this definition, "nursing facility" means the business operation, not the physical property. A "new provider" retains that status until the start of the prospective Rate Period corresponding to the provider's first, full twelve-month Report Period.

Example A: A new provider enters the Medicaid program on May 7, 2007. Their first full, twelve-month Report Period is for the period ending June 30, 2008, which corresponds to the prospective Rate Period beginning July 1, 2009. They are a "new provider" from May 7, 2007 through June 30, 2009.

Example B: A new provider enters the Medicaid program on July 1, 2007. Their first full, twelve-month Report Period is for the period ending June 30, 2008, which corresponds to the prospective Rate Period beginning July 1, 2009. They are a "new provider" from July 1, 2007 through June 30, 2009.

Definition: The "Report Period" for a fiscal year determines rates, or interim rates, for a "prospective Rate Period" two years after the Report Period. For example, Report Period 2006-2007 determines prospective rates, or interim rates, for the 2008-2009 Rate Period.

12-011.08H1 Medicaid rates for new providers, except for IHS nursing facility providers, are determined as follows:

1. New providers entering the Medicaid program as a result of a change of ownership:

For the Rate Period beginning on the date ownership is transferred through the following June 30, new providers entering the Medicaid program as a result of a change of ownership receive interim Medicaid rates equal to the rates of the seller in effect on the date ownership is transferred, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the Report Period beginning on the date ownership is transferred through the following June 30, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a Report Period do not file a cost report and are not subject to a retro-settlement of their rates.

For the following July 1 through June 30 Rate Period, new providers receive interim rates computed from the seller's audited cost report for the corresponding Report Period, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

If applicable, for the next July 1 through June 30 Rate Period, new providers receive interim Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the date ownership is transferred and ending the following June 30, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

2. New providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid:

For the Rate Period beginning on the Medicaid certification date through the following June 30, new providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid receive interim Medicaid rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending on the following June 30, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a Report Period do not file a cost report and are not subject to a retro-settlement of their rates.

For the following July 1 through June 30 Rate Period, new providers receive initial interim rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, computed using audited data following the initial desk audits. The initial interim rates are revised based on the provider's audited Medicaid cost report for their first Report Period, subject to maximums and limitations applicable to the Rate Period. The revised interim rates will be issued within ten days of the completion of the initial desk audit of the facility's cost report. The revised interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

If applicable, for the next July 1 through June 30 Rate Period, new providers will receive interim Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

12-011.08H2 Medicaid rates for new IHS nursing facility providers are determined as follows:

1. New providers entering the Medicaid program as a result of a change of ownership:

For the Rate Period beginning on the date ownership was transferred through the following June 30, new providers entering the Medicaid program as a result of a change of ownership receive Medicaid rates equal to the rates of the seller in effect on the date ownership was transferred, subject to maximums and limitations applicable to the Rate Period.

For the following July 1 through June 30 Rate Period, new providers receive rates computed from the seller's audited cost report for the corresponding Report Period, subject to maximums and limitations applicable to the Rate Period.

If applicable, for the next July 1 through June 30 Rate Period, new providers receive Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the date ownership was transferred and ending the following June 30, subject to maximums and limitations applicable to the Rate Period.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

2. New providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid:

For the Rate Period beginning on the Medicaid certification date through the following June 30, new providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid receive Medicaid rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification.

For the following July 1 through June 30 Rate Period, new providers receive rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, computed using audited data following the initial desk audits.

If applicable, for the next July 1 through June 30 Rate Period, new providers will receive Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

12-011.08K Special Funding Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transaction to increase reimbursement. The transaction is subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonable be estimated to be paid under Medicare payment principles). City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility.

City or county-owned facilities with a 40 percent or more Medicaid mix of inpatient days are eligible to receive the Federal Financial Participation share of allowable costs exceeding the applicable maximums for the Direct Nursing and the Support Services Components. This amount is computed after desk audit and determination of final rates for a Report Period by multiplying the current Medicaid Federal Financial Participation percentage by the facility's allowable costs above the respective maximum for the Direct Nursing and the Support Services Components. The participating facility certifies the non-federal share of cost. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.

12-011.08L Special Funding Provisions for IHS Nursing Facility Providers: IHS nursing facility providers are eligible to receive the Federal Financial Participation share of allowable costs exceeding the rates paid for the Direct Nursing, Support Services and Fixed Cost Components for all Medicaid residents.

1. IHS providers may receive quarterly, interim Special Funding payments by filing quarterly cost reports (FA-66) for periods ending September 30, December 31 and/or March 31. Quarterly, interim Special Funding payments are retroactively adjusted and settled based on the provider's corresponding annual cost report for the period ending June 30. Quarterly, interim payments and the retroactive settlement amount are calculated in accordance with Section C below. If the average daily census from a quarterly cost report meets or exceeds 85% of licensed beds, this shall be the "final" quarterly cost report filed by the provider. Subsequent quarterly, interim Special Funding payments shall be based on the "final" quarterly cost report. Quarterly, interim Special Funding payments may also be revised based on data from the annual cost reports.

2. Quarterly, Interim Special Funding payments shall be made within 30 days of receipt of the quarterly cost report or requested supporting documentation. Quarterly, interim Special Funding payments subsequent to the payment for the "final" quarterly cost report shall be made on or about 90-day intervals following the previous payment.

3. The Special Funding amount is computed after desk audit and determination of allowable costs for the report period. The amount is calculated by adding the following two figures:

a. The allowable Federal Medical Assistance Percentage for IHS-eligible Medicaid residents multiplied by the difference between the allowable costs for all IHS-eligible Medicaid residents and the total amount paid for all IHS-eligible Medicaid residents, if greater than zero: and
b. The allowable Federal Medical Assistance Percentage for non-IHS eligible Medicaid residents multiplied by the difference between the allowable costs for all non-IHS-eligible Medicaid residents and the total amount paid for all non-IHS-eligible Medicaid residents, if greater than zero.

12-011.08M (Reserved)

12-011.09 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

At the time of an asset acquisition, the nursing facility must use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 12-011.06H and J.

12-011.09A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

12-011.09B Capitalization Guidelines: Providers must devise and follow a written capitalization policy within the following guidelines. A copy of the policy must be available upon request by the Department.

12-011.09B1 Capitalization Threshold: The capitalization threshold is a pre-determined amount at which asset purchases must be capitalized rather than expensed. Each provider determines the capitalization threshold for their facility, but the threshold amount must be at least $100 and no greater than $5,000.

12-011.09B2 Acquisitions: If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and an allowable cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has an allowable cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

12-011.09B3 Acquisitions Under $100: Acquisitions after July 1, 2005 with a per unit cost of less than $100 cannot be depreciated. Costs of these items are included in the applicable operating cost category on the Cost Report in the current period.

Examples:

Item	Per Item Cost	Account
Toaster	$38	Dietary Supplies
30 Wastebaskets	$22 ($660 total)	Housekeeping Supplies
Calculator (bookkeeper)	$95	Administration Supplies
Pill Crusher	$62	Nursing Supplies
Wrench Set	$77	Plant Related Supplies

12-011.09B4 Integrated System Purchases: When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.

12-011.09B5 Multiple Items with Per Unit Cost Greater Than or Equal to $100: Items that have a stand-alone functional capability may be considered on an item-by-item basis or as an aggregate single purchase. Each provider's capitalization policy must describe how the provider elects to treat these items. For example, depending on the provider's capitalization policy, stand-alone office furniture (e.g., chairs, freestanding desks) with per item costs that are under the capitalization threshold may be expensed as numerous single items, or the total cost of all items may be capitalized as an aggregate single purchase.

12-011.09B6 Non-Capital Purchases: Purchases of equipment and furnishings over $100 per item and under the provider's capitalization threshold are included in the Plant Related cost category on the Cost Report in the current period.

12-011.09B7 Betterments and Improvements: Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (e.g., asbestos removal) of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

For the costs of betterments and improvements, the guidelines in 471 NAC 12-011.09B1 through 12-011.09B6 must be followed. For example, if the cost of a betterment or improvement to an asset is equal to or exceeds the capitalization threshold and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, or the safety of the asset is increased significantly, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement.

12-011.09B8 The following examples show the cost report treatment of various purchases under two different capitalization policies:

Example A
Provider A's written capitalization policy has a $5,000 threshold for single item purchases. Purchases of multiple items are treated on an item-by-item basis.

Item	Per Item Cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Plant Related – as per item cost is less than $5,000
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Plant Related
Range/Oven	$4,900	Plant Related
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Plant Related – as per item cost is less than $5,000
3 Cubicle Walls & Desktop for an Office Cubicle	$300 (total = $900) $700 (total = $1,600)	Plant Related – as total cost of integrated cost is less than $5,000

Example B
Provider B's written capitalization policy has a $1,500 threshold for single item purchases. Multiple item purchases are treated as an aggregate single purchase.

Item	Per Item Cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Capitalize & Depreciate
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Capitalize & Depreciate
Range/Oven	$4,900	Capitalize & Depreciate
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Capitalize & Depreciate – as aggregate cost of $7,000 is more than $1,500
3 Cubicle Walls & – Desktop For an Office Cubicle	$300 (total = $900) $700 (total = $1,600)	Capitalize & Depreciate as cost of integrated system is greater than $1,500

12-011.09C Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;
3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 12-011.06H and J);
4. Based on the fair market value at the time of donation in case of donated assets. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

12-011.09D (Reserved)

12-011.09E Recapture of Depreciation: Depreciation in 471 NAC 12-011.08E refers to real property only. A nursing facility which converts all nursing facility beds to assisted living beds is not subject to recapture provisions. A nursing facility which is sold for a profit and has received NMAP payments for depreciation must refund to the Department the lower of:

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times (\text{Sales Price - Book Value})$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

In the above calculations of the recapture of depreciation, if a facility has been limited to the maximum payment for the fixed cost component (see 471 NAC 12-011.08D3), then that facility's allowable individual expense categories of the fixed cost component must be proportionately prorated to determine the amount that is attributable to depreciation.

Examples:		Data
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4-2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

12-011.09F Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

12-011.09G Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

12-011.10 Reporting Requirements and Record Retention: Providers with greater than 1,000 Medicaid inpatient days for a full Report Period must submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation will prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes.

Each facility must complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 45 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider must maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a required cost report has not been filed, the sum of the following is due:

1. All prospective rate payments made during the rate period to which the cost report applies;
2. All prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department will retain all cost reports for at least five years after receipt from the provider.

Facilities which provide any services other than certified nursing facility services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. A Medicare certified facility must not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

12-011.10A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Health and Human Services, Division of Medicaid and Long-Term Care, Audit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the nursing facility name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Lincoln State Office Building address; pick up copies at that office; or mail copies). The total fee, based on current Department policy (http://www2.dhhs.ne.gov/policies/PublicRecords.pdf), must be paid in advance. The nursing facility will receive a copy of a request to inspect its cost report.

12-011.11 Audits: The Department will perform at least one initial desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Care classification maximums and average base rate components are computed using audited data following the end of the Cost Report Period. Subsequent desk and field audits will not result in a revision of care classification maximums or average base rate components.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider must deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit:

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 12-011.15 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 12-011.15 #2 or when grounds exist to suspect that fraud or abuse has occurred.

12-011.12 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department will determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on a remittance advice. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion.

The Department will determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department will immediately begin recovery from future facility payments until the amount due is fully recovered.

The Department will report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

12-011.13 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of $25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than $25,000, or both.

12-011.14 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Division of Medicaid and Long-Term Care within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis or explanation of each item, or both. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director of the Division of Medicaid and Long-Term Care issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

12-011.14A MDS 2.0 Reconsideration Process (effective only through September 30, 2010: In place of or in advance of requesting an administrative appeal, a facility may request a rate payment reconsideration with the Department or its designee for a specific Level of Care 101, 102, 103 or 104 resident. The facility must submit information on the client's need for professional medical care, supervision or other needs that justify a rate payment at Level 191, 192, 193 or 194. Note: The reconsideration process neither limits nor promotes the facility's responsibility to make MDS changes on a quarterly basis or whenever a significant change has occurred, as federally defined.

To request reconsideration, the facility must submit information on the resident's needs, with supportive documentation, to the Department or its designee. The supportive documentation must include the degree of instability involved and the frequency of intervention in one or more of the following areas of the MDS 2.0:

1. Section B.5. Indicators of delirium, periodic disordered thinking awareness, for residents with the diagnosis of mental illness, mental retardation or a related condition (developmental disability), dementia, or a brain injury. The behavior must be present and not of recent onset (Code 1).
2. Section E.1. Indicators of depression, anxiety, and/or sad mood. The behavior must be exhibited (Code 1 or 2) PLUS an indicator in Section I of a disease of psychiatric/mood.
3. Section J. Health Conditions (present in the last 7 days unless other time frame is indicated) that affect the stability of condition and/or require professional nurse monitoring.
4. Section O. Medications that require professional nurse administration and/or monitoring.
5. Section P. Special Treatments and Procedures #2 for Section E indicators and Section I disease of psych/mood.

Other documentation supporting the need for nursing judgement or intervention may also be submitted.

The following conditions do not constitute valid reasons for reconsideration:

1. Lack of informal support;
2. Amount of time the person has resided at the nursing facility, with payment either through Medicaid or through another source;
3. Presence of a specific diagnosis without supporting documentation of the need for nursing judgement or intervention; and
4. Advanced age.

12-011.14A1 Effective Date of Reconsideration: A facility may request a rate reconsideration review for MDS 2.0 assessments by December 31, 2010. If granted, the adjusted rate will be effective the first day of the month for which the resident's need for medical supervision or intervention is documented, retroactive for a period not to exceed three calendar months before the first day of the month in which the reconsideration request and supporting documentation is received by the Department or its designee.

12-011.15 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director of the Division of Medicaid and Long-Term Care to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken:

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director of the Division of Medicaid and Long-Term Care will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director of the Division of Medicaid and Long-Term Care that a reopening or correction of a determination or decision is not warranted.

12-011.16 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under 471 NAC 12-011 must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under 471 NAC 12-011 has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

12-012 Completion of Form FA-66, "Long Term Care Cost Report": All providers participating in NMAP must complete Form FA-66 according to the instructions in 471 NAC 12-012. Form FA-66 consists of Schedules "General Data," A (Parts 1 and 2), B (Parts 1, 2, 3, and 4), B-1, B-2, B-3, B-4, B-5, C, D, (Parts 1, 2, and 3), D-1, E (Parts 1 and 2), E-1, F (Parts 1 and 2), "Preparer Acknowledgement" and "Certification by Officer, Owner, or Administrator." (See 471-000-41 for an example of all schedules.)

12-012.01 Who Must File: Any long term care provider located in Nebraska that has a long term care provider agreement with the Department must report its costs on Form FA-66, "Long Term Care Cost Report."

12-012.02 When to File: The provider must file the cost report within 90 days after:

1. The end of the report period;
2. A change of ownership or management; or
3. Termination from the Nebraska Medical Assistance Program.

12-012.03 What to File: The provider must submit the original signed cost report, including all standard schedules included in the cost report package, all attachments to the schedules, and the preparer's report. A provider who does not need to complete any particular schedule in the report package must mark the schedule as not applicable (N/A).

12-012.04 Where to File: The provider must submit the original signed and completed report to:

Nebraska Department of Health and Human Services
Fifth Floor – Audit Unit
301 Centennial Mall South
P. O. Box 95026
Lincoln, NE 68509-5026

12-012.05 Completion Parameters: The preparer must complete the report within the following parameters set for consistency in the report process:

1. Round all dollar values to the nearest dollar. DO NOT report the cents.
2. Round all percentages to the nearest hundredth of a percent (.80005=80.01%).
3. If additional lines are needed, reference an attachment and include a summary figure on the standard report form.
4. Report only one amount in an entry area.

12-012.06 Completion Procedure: The individual preparing the report must complete the schedules for the report as described in the instructions. The following paragraphs provide a suggested order for completion of the report.

Specific information about each schedule begins at 471 NAC 12-012.07.

Complete all the items in the GENERAL DATA schedule.

Determine the license and certification levels at the beginning and the end of the report period. Obtain license changes issued by HHS R & L during the report period. Obtain certification changes issued by the Department during the report period.

Complete SCHEDULE A, PART 1.

Obtain the monthly detailed census records. Identify any adjustments needed for the cost report.

Complete SCHEDULE A, PART 2.

Obtain the prior year's cost report and any adjustments made subsequent to its completion. Obtain the adjusted trial balance from the provider's accounting records.

Complete: SCHEDULE B, PART 1, COLUMN B
SCHEDULE B, PART 2, COLUMN B
SCHEDULE B, PART 3, COLUMN B
SCHEDULE B, PART 4, COLUMN B
SCHEDULE C

Review the General Cost category on Schedule B, Part 3, and determine if cost adjustments are needed to reclassify payroll taxes or employee benefits.

Complete SCHEDULE B-1 to adjust the general cost category.

Review the costs to determine any other costs that need to be adjusted between cost centers and/or account descriptions to reflect the correct report classification.

Record the reclassification adjustments on SCHEDULE B-4. Use the blank space provided for other adjustments.

Review the costs in the operating and ancillary categories, considering the reclassification adjustments, and determine if any of the costs are the result of transactions with related organizations.

Complete SCHEDULE B-2, if any of the costs are with related organizations.

Review the payroll costs, considering the reclassification adjustments and determine if any of the payroll is paid to owners, directors, or other related parties.

Obtain job descriptions for all owners, directors, or other related parties who received compensation.

Complete SCHEDULE B-3 if any of the payroll includes payments to owners, directors, or related parties.

Review the revenue and cost and determine if any other operating or ancillary costs are included that cannot be considered for reimbursement. Determine how to make the necessary changes for reimbursement -

- offset of the related revenue,
- direct cost adjustment, or
- allocation of the costs.

Record revenue offsets on: SCHEDULE B, PART 1, Columns C & D
SCHEDULE B, PART 2, Columns C & D

Record direct cost adjustments on SCHEDULE B-4. Use the defined lines when possible. Use the blank lines for other adjustments.

Note any items to be allocated. Allocations are completed later in the report process.

Obtain copies of the signed leases if amounts are reported for fixed long term leases.

Review the leases and determine if any adjustments are necessary for leases not related to the long term care portion of the facility.

Record the adjustments on SCHEDULE B-4. Use the blank lines provided for other adjustments.

Complete SCHEDULE F, PART 1, lines 1 through 5 for all remaining fixed long term lease costs.

Complete SCHEDULE F, PART 2 for each lease that may involve ownership cost adjustments.

Complete SCHEDULE F, PART 1, lines 6 through 18. Transfer total lease adjustment data to the other schedules as indicated on the form.

Obtain an itemized depreciation schedule if depreciation is included in the reported cost.

Complete SCHEDULE D, PART 1, Columns B and C.

Review the assets listed on the detailed depreciation schedule and determine if any adjustments are necessary to remove assets not used in the long term care program or to adjust the cost bases for Medicaid reimbursement.

Report the fixed asset cost adjustments on SCHEDULE D-1.

Summarize the Schedule D-1 adjustments on SCHEDULE D, PART 1, Column D.

Complete the remainder of SCHEDULE D, PART 1. Transfer the adjustment from Line 30 to SCHEDULE B-4 as indicated on the form.

Complete SCHEDULE D, PART 2 if any assets have been added to the long term care value during the report period.

Complete SCHEDULE D, PART 3 if any assets have been removed from the long term care value during the report period.

Obtain copies of signed loan agreements if interest is included in the reported cost.

Complete SCHEDULE E, PART 1, Columns A, B, C, D, E, and F.

Review the loan agreements and determine if any adjustments are needed to remove loans not related to long term care or to change the loans to amounts allowable for Medicaid reimbursement.

Report the loan adjustments on SCHEDULE E-1.

Summarize the Schedule E-1 adjustments on SCHEDULE E, PART 1, Column G.

Complete the remainder of SCHEDULE E, PART 1. Transfer the adjustments from Line 11 to SCHEDULE B-4 as indicated on the form.

Complete SCHEDULE E, PART 2. Transfer the adjustment to Schedule B-4 as indicated on the form.

Summarize the revenue offsets (Schedule B, Parts 1 and 2) on SCHEDULE B, PART 3, Column C.

Summarize the cost adjustments (Schedule B-1, B-2, B-3, and B-4) on SCHEDULE B, PART 3, Column D.

Complete SCHEDULE B, PART 3, Column E.

Review the costs for allocation and determine the appropriate allocation basis for each line. Obtain the statistical records maintained by the provider.

Complete SCHEDULE B-5. Report only the statistics needed to complete the allocations.

Complete SCHEDULE B, PART 3, Column F. EACH LINE WITH AN AMOUNT TO ALLOCATE MUST HAVE A SCHEDULE B-5 ALLOCATION BASIS NUMBER RECORDED IN COLUMN F.

Complete SCHEDULE B, PART 3, Columns G and H.

Review all the information contained in the report. Make sure that all schedules are completed and that the information is correct.

The preparer completes the "Preparer Acknowledgement" at the end of the report packet and attaches the preparation report.

The owner, officer, or administrator authorized to act on behalf of the provider must review the report and complete the certification.

ALL REPORTS MUST BE SIGNED BY THE PROVIDER MANAGEMENT.

12-012.07 General Data

12-012.07A Description: The General Data Section, located on page 1 of the report form, is used to report information about the provider, the cost report, and the accounting records.

12-012.07B Definitions: Definitions of the information requested on of the General Data section follow.

1. Provider Number - Report the Medicaid long term care provider number assigned to the nursing facility. If the number changed during the report period, report the provider number in effect at the end of the period. Include one character in each field of the entry area. All fields, including the two digit suffix, must be completed.

2. Mailing Address - Report the commonly used facility name and the address used to receive mail for the facility.

3. Location Address - Report the street address if it is not used in the mailing address.

4. Telephone Number - Report the telephone number for the facility. If the facility has more than one number, include the number of the administrative offices.

5. Location in an Urban Area - Mark the appropriate box:

   YES, if the facility is located in Douglas, Lancaster, Sarpy, or Washington County.
   NO, if the facility is located in any other county.

6. Licensed as - Mark the box that applies to the facility:

   NURSING FACILITY, if the facility is licensed by HHS R & L as a Nursing Facility.
   HOSPITAL, if the facility is licensed by HHS R & L as a hospital.

7. Long Term Care Certified for - Mark the box or boxes that apply at any time during the report period:

   NF, if the facility had any or all beds certified for nursing facility only.

   Waivered - Mark the box that applies to the facility:

   YES, if the facility was waivered at any time during the report period.

   NO, if the facility was not waivered at any time during the report period.

   ICF/MR, if the facility had any or all beds certified for intermediate care of the mentally retarded services.

8. Type of Control - Mark the box that describes the provider's organizational structure. The choices are self-explanatory.

9. Medicare Participation - Mark the boxes that apply:

   YES, if the facility participates in the Medicare Part A and/or Part B program.
   NO, if the facility does not participate in the Medicare program.

   If yes was marked, report the provider number assigned for participation in the Medicare program and the fiscal intermediary for the Medicare program.

10. Report Period - Report the beginning and the ending dates of the period covered by the cost report. Include a character in each field of the entry area. Use leading zeros when needed.

    Example: 07:01:03 to 06:30:04 for report period ended June 30, 2004.

11. Report Type - Mark the boxes that apply:

    REGULAR REPORT PERIOD, if the report is for a full report period of July through the following June.

    CLOSING, if the report period includes the date NF services or participation in the NMAP discontinued at the facility.

    OPENING, if the report period includes the date NF services or participation in the NMAP started at the facility.

12. Facility Regular Fiscal Year - Report the annual period used in the provider's normal course of business. It may be different than the report period used for the Nebraska Long Term Care Cost Report.

13. Central Office for Chain Providers - If the provider is an entity of a chain of providers, report the central office name, address, and telephone number. If applicable, also include the name of the person in the central office responsible for or most familiar with coordination with the Medicaid programs.

14. Accounting Records Maintained at - Report the name, address, and telephone number of the office where the major portion of the provider's accounting records are located. If this is the same as another address reported in the General Data section, a reference to that item number may be reported rather than repeating the information.

15. Accounting Firm and Representing Accountant - Report the name, address, and telephone number of any accountant or accounting firm used by the provider for accounting, auditing, report preparation or other activity related to the financial records of the provider. Also report the name of the individual at the firm most familiar with the work done for the provider.

16. Does the facility have an annual certified audit? Mark the box that applies:

    YES, if the provider's financial records for any portion of the report period were included in a certified audit conducted by a licensed certified public accountant.
    NO, if the provider's financial records have not been audited by a licensed certified public accountant.

    Complete all boxes in the General Data Section. If a particular item does not apply to the provider, mark that item as not applicable (N/A). If more space is needed for an item write "See Attachment ##" and report the information on an attached sheet.

12-012.08 Schedule A, Occupancy Data, Description: Schedule A is a two-part schedule located on pages 1 and 2 of the report form.

12-012.08A Schedule A, Part 1, Required Occupancy, Description: Part 1, located on page 1 of the report form, is used to report the provider's long term care licensure and certification information for all days during the report period. It includes space to report any changes that occurred during the period. This part is also used to determine bed days available and report the bed days subject to the occupancy limitations used by the Department.

12-012.08B Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule A.

A Period Covered - Report the period that each license or certification level was in effect. The first date entered is the first day of the report period. The last date entered is the last day of the report period. Report each change as it was approved by HHS R & L and the Department. Display entries in this column as month, day, and year (example: July 1, 2004 is displayed 7/1/04).

B Days Covered - For each "period covered" entered in Column A, compute the number of days that the licensure/certification was in effect. The total of all lines will be 365 for a full report period (366 for leap years).

C Number of Licensed Beds Certified for NF Services - Report the long term care beds licensed and certified for nursing facility services.

D NF Bed Days Available - Multiply the number of days reported in Column B by the NF certified beds in Column C and record the result in this column.

Add the bed days available in Columns D and record the totals on Line 2.

On Line 3 report the number of bed days available meeting the conditions for the 50 percent occupancy limitation. Report the remaining bed days available on Line 4.

DO NOT WRITE IN THE BLANK SPACES AT THE END OF THE SCHEDULE.

If additional lines are needed, mark "See Attachment ##", report the information on the attached sheet, and transfer the totals of Columns B and D from the attachment to the form.

12-012.08C Schedule A, Part 2, Census Data, Description: Part 2, located on page 2 of the report form, is used to report the patient services provided. Lines 1 through 3 apply to NF services provided and line 4 applies to other services provided at the facility.

12-012.08D Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule A.

A Month - Sets the order for reporting monthly information. Use only the months covered by the cost report.

In Columns B through J, the Column titles used in the definition will refer to "Long Term Care Services". Report the requested census data for NF services on Line 1 through 3.

B Long Term Care Services; Private; In-House - Report the number of days that a private resident actually occupied a long term care bed at midnight. A private resident is responsible for payment of the facility established rate for services provided.

C Long Term Care Services; Private; Hold - Report the number of days that a bed was actually held for a private resident, subject to limitations at 471 NAC 12-011.06B.

D Long Term Care Services; Private; Total - Add Column B and Column C and record the total in this column.

E Long Term Care Services; Nebraska Medicaid; In-House - Report the number of days that a Nebraska Medicaid resident actually occupied a long term care bed at midnight. A Nebraska Medicaid resident is a resident whose service has been paid by the Department.

F Long Term Care Services; Nebraska Medicaid; Hold - Report the number of days that a bed was actually held for a Nebraska Medicaid resident, subject to limitations at 471 NAC 12-011.06B.

G Long Term Care Services; Nebraska Medicaid; Total - Add Column E and Column F and record in the total in this column.

H Long Term Care Services; Other NF; In-House - Report the number of days that other long term care residents actually occupied a long term care bed at midnight. Other long term care residents include residents for whom services are paid by another State's Medicaid program, Medicare, Veterans, or other programs.

I Long Term Care Services; Other NF; Hold - Report the number of days that a bed was actually held for other long term care residents, subject to limitations at 471 NAC 12-011.06B.

J Long Term Care Services; Other NF; Total - Add Column H and Column I and record the total in this column.

The titles used for definitions of Columns K through M refer to "Other Than Long Term Care". Report residential or other services (not NF) provided in the long term care beds.

K Other Than Long Term Care; In-House - Report the number of days that other residents actually occupied a long term care bed at midnight.

L Other Than Long Term Care; Hold - Report the number of days that a long term care bed was actually held for other residents.

M Other Than Long Term Care; Total - Add Column K and Column L and record the total in this column.

Add the census days reported on each column of Item 1 and record the totals on Line 2.

Add the days reported on Line 2, Columns D, G, and J and record the "Total NF Days" on Line 3. Copy the total from Line 2, Column M to "Total Other Days" on Line 3.

Report census days for services provided in areas not licensed for long term care, including all hold days, on line 4.

An inpatient day is counted at midnight. Midnight is the end of a day; therefore, count the day of admission and not the day of dismissal. Report one day for an individual admitted and deceased on the same day.

All hold days are reported consistent with the limitations imposed for payment by the Nebraska Medicaid program. Therefore, all resident hold days are limited to 15 per hospital stay and 18 per year for therapeutic home visits, REGARDLESS OF THE NUMBER OF DAYS PAID. (36 therapeutic home visits for ICF/MR residents.)

12-012.09 Schedule B, Revenue and Costs, Description: Schedule B is a four-part schedule located on pages 3 through 15 of the report form.

12-012.09A Schedule B, Part 1, Patient Revenues, Description: Patient Revenues includes four sections: Medicaid LTC Patient Revenues and the Private LTC Patient Revenues sections, located on page 3, and Other Payor LTC Patient Revenues and Other Than LTC Patient Revenues sections, located on page 4. The first three sections are used to report revenue from long term care services. The fourth section is used to report patient revenues not related to the long term care program.

This part of the schedule is also used to report any amounts included in the patient revenues which should be used to offset the costs.

12-012.09B Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category/Account Description - This column provides the description of the information requested. Most account descriptions are on the form. Some description lines are blank to report patient revenue accounts not meeting the account descriptions included. Do not substitute for the account descriptions.

B Facility Trial Balance - Report amounts from the provider's trial balance. If a revenue account has a debit balance (a negative revenue) include brackets around the reported amount.

C Amount to Offset Cost - Report any amount included in the revenue which represents a recovery of a cost not related to covered long term care service. Do not report a revenue offset if the actual costs have been identified or adjusted through some other report process to remove the cost from the reimbursable amount. Using revenue offsets is a short cut to removing the corresponding cost. The provider must be able to show that the offset used is representative of the corresponding cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

D Part 3 Line Number to Offset - Report the line number from Schedule B, Part 3 where the offset applies. Part 3 includes lines to apply offsets to categories in total when the offset cannot be applied to a specific cost account.

Nebraska Medicaid Patient Revenues - Report the patient revenues related to residents covered by the Nebraska Medicaid Program. The revenue for services includes ALL payments received from all sources for those residents. Revenue reported in this section is NOT limited to the State payment.

Private LTC Patient Revenues - Report the patient revenues related to long term care residents who are responsible for independent payment of the provider established rates. Do not report the portion of the Medicaid rate paid by the Medicaid resident. That amount must be included in the Medicaid Revenue section.

Other Payor LTC Patient Revenues - Report the patient revenues related to long term care residents covered by other long term care service programs, (i.e., another State's Medicaid, Medicare, Veterans, Hill-Burton, or others) in this section.

Other than LTC Patient Revenues - Report revenue from all other inpatient services in this section. This would include every type of patient service for residents not included in the long term care revenues. Report other patient revenues not meeting the descriptions on lines 98 through 110. Do not include revenue related to long term care service on these lines.

Complete all total lines. Report the grand totals on Line 112. Transfer the amount from Column B, Line 112 to Schedule B, part 4, Line 1.

DO NOT REPORT MORE THAN ONE AMOUNT IN AN ENTRY AREA.

INDICATE NEGATIVE AMOUNTS WITH BRACKETS.

DO NOT USE LINES 15 TO 28, 43 TO 56, AND 71-84.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS. If the blank lines are not adequate to report all the accounts from the provider's trial balance, write in "SEE ATTACHMENT ##", list the accounts on the attachment and show the total amounts on the form. All offsets must be reported on the form. Report a line number to offset for each amount to be offset.

If more than one line is to be offset, use the blank lines, reference the source line in the account description column, and record the offsets in Columns C and D.

12-012.09C Schedule B, Part 2, Other Revenue, Description: Part 2, located on page 5 of the report form, is used to report all other revenue recorded on the provider's trial balance, and any amount in the accounts that should offset cost.

12-012.09D Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category/Account Description - The column includes descriptions for common revenue accounts. Several lines are blank for other revenue accounts not meeting the descriptions included on the form. Do not substitute for the account descriptions.

B Facility Trial Balance - Report the amount recorded in the provider's trial balance. If a revenue account has a debit balance (a negative revenue) include brackets around the reported amount.

C Amount of Offset Cost - Report any amount included in the revenue which represents a recovery of a cost not related to covered long term care services. Do not report a revenue offset if the actual costs have been identified and adjusted through some other report process to remove the cost from the reimbursable amounts. Using revenue offsets is a short cut to removing the corresponding costs. The provider must be able to show that the offset used is representative of the corresponding cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

For account descriptions included on the form, two lines are included for reporting offsets related to the revenue. These are provided in order to apply the offset to more than one cost center. If additional lines are needed to complete the offset, use Lines 19 through 46.

D Part 3 Line Number to Offset - Report the Schedule B, Part 3 line number where the offset applies. Part 3 includes lines to apply offsets to categories in total when the offset cannot be applied to a specific account.

If additional lines are needed write "See Attachment ##" in Column A, attach a summary, and record the totals from the attachment on the form. Each amount to be offset must be identified on the form. Therefore, allow space to record the related offsets by line when transferring summary information from the attachment to the form.

Offset unidentified or miscellaneous revenues to Schedule B, Part 3, Line 185.

Add the amounts in Columns B and C and enter the total on Line 47. Transfer amount from Column B to Schedule B, Part 4, Line 2.

DO NOT REPORT MORE THAN ONE AMOUNT IN AN ENTRY AREA.

INDICATE NEGATIVE AMOUNTS WITH BRACKETS.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS.

REPORT A LINE NUMBER TO OFFSET FOR EACH AMOUNT TO BE OFFSET.

12-012.09E Schedule B, Part 3, Costs and Allocations, Description: Part 3, located on pages 6 through 14 of the report form, is used to report all costs from the accounting records. The revenue offsets are summarized. The cost report adjustments are summarized. The allocations to the reimbursable and nonreimbursable cost centers are completed. The provider identifies the reimbursable costs which the Department will use to set the rate.

12-012.09F Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Line No. - The line numbers provide reference to the account descriptions. They are used in other schedules to relate offsets and adjustments to the appropriate lines of this part of Schedule B. Offsets and adjustments recorded on the other schedules include columns to identify the "Part 3 line number". Use the line numbers from this column to make those references.

Cost Category/Account Description - The cost categories are provided to identify the grouping of the accounts. Because of the various limitations and calculations used in setting rates, COSTS MUST BE REPORTED IN THE PROPER REPORT CLASSIFICATION.

Each category includes several account descriptions. Most categories include blank lines for accounts not fitting the descriptions. In addition, the categories include a line to report costs that are not reimbursable and a line to summarize the category revenue offsets. Do not substitute for the account descriptions on the form. Do not include costs for therapies, other than respiratory, after December 31, 1991.

B Facility Trial Balance - Report the amount from the trial balance for each applicable account description. If the cost account has a credit balance (a negative cost), include brackets to indicate the negative amount.

C Revenue Offsets - Summarize the revenue offsets reported on Parts 1 and 2 of Schedule B. Offsets are normally reductions of the cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

D Cost Report Adjustments - Summarize the cost report adjustments reported on Schedules B-1, B-2, B-3, and B-4. The adjustments in this column decrease the cost unless the amount is recorded with brackets.

E Cost For Allocation - Subtract the revenue offsets and cost report adjustment amounts from the trial balance amount and record the difference in this column.

F Allocation Basis No. - Record the basis number from Schedule B-5 which is to be used to allocate the amount in Column E. EACH LINE WITH AN AMOUNT IN COLUMN E MUST HAVE AN ALLOCATION BASIS INDICATED IN THIS COLUMN. Use 1 if the entire account is NF, 3 if the account is all nonallowable/other, and 0 if specific accounting is used to identify the cost for the NF or nonallowable/other. Use -0- in this column if the distribution to the cost centers is based on actual costs identified in the records. Allocation methods other than 0, 1, or 3 must be approved by the Department before use. Costs not reported in the proper report classification must use allocation basis 3.

G Allowable Long Term Care - Report the cost distribution for amounts related to the nursing facility. The distribution must be computed according to the allocation basis indicated in Column F. THE AMOUNTS IN COLUMN 'G' MUST REPRESENT ONLY THE NF PORTION OF COSTS ALLOWABLE FOR REIMBURSEMENT.

H Unallowable and Other - Report the cost distribution for amounts not related to NF. The distribution must be computed according to the allocation basis indicated in Column F.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS ON THE FORM.

DO NOT REPORT MORE THAN ONE ITEM IN AN ENTRY AREA.

REPORT AN ALLOCATION BASIS NUMBER FOR EACH LINE INCLUDING AN AMOUNT TO ALLOCATE.

12-012.09G Schedule B, Part 4, Revenue and Cost Summary, Description: Part 4, located on page 15 of the report form, is used to summarize the revenue and cost information and report the net revenue or loss for the provider. Most of the information for this part of the Schedule is obtained from other lines in Parts 1, 2, and 3 of Schedule B.

12-012.09H Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category - The category describes the information to be reported in Column B.

B Amount - Report the corresponding trial balance totals from Parts 1, 2, and 3 or the other information indicated below.

1 Total Patient Revenue - Report the amount from Part 1, Column B, Line 112.

2 Total Other Revenue - Report the amount from Part 2, Column B, Line 47.

3 Total Revenue - Add the amounts on Lines 1 and 2 and report on this line.

4 Administration - Report the amount from Part 3, Column B, Line 34.

5 General - Report the amount from Part 3, Column B, Line 45.

6 Dietary - Report the amount from Part 3, Column B, Line 63.

7 Housekeeping - Report the amount from Part 3, Column B, Line 78.

8 Laundry - Report the amount from Part 3, Column B, Line 93.

9 Nursing - Report the amount from Part 3, Column B, Line 128.

10 Plant - Report the amount from Part 3, Column B, Line 163.

11 Activities and Social Services - Report the amount from Part 3, Column B, Line 184.

12 Total Operating Cost - Add the amounts on Lines 4 through 11 and record the total on this line.

13 Total Ancillary Cost - Report the amount from Part 3, Column B, Line 232.

14 Total Fixed Cost - Report the amount from Part 3, Column B, Line 249.

15 Total Cost Centers-Not Reimbursable - Report the amount from Part 3, Column B, Line 258.

16 Total Costs - Add the amounts on Lines 12 through 15 and record the total on this line.

17 Net Income Before Tax - Subtract Line 16 from Line 3 and record the difference on this line.

18 Income Tax Provision - If applicable, report the income tax provision as recorded on the records of the provider.

19 Net Income After Tax - Subtract Line 18 from Line 17 and record the total on this line.

Do not report more than one amount for any one entry area.

12-012.09J Schedule B-1, General Cost Allocation and Adjustment, Description: Schedule B-1, located on page 16 of the report form, is used to complete the allocation of the costs reported in the general cost category.

12-012.09K Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-1.

A Payroll Category - These are the payroll account descriptions included in Schedule B, Part 3.

B Salaries, Wages, Other Compensation Reported - Report the amounts on this line that are reported for the corresponding account descriptions in Schedule B, Part 3. If any adjustments are made to the salary accounts before completion of this form, include the adjusted amounts in this column.

C Exemption - Report any adjustment to the salary needed to set a reasonable basis for the allocation of the FICA tax. This column relates primarily to situations where individual payrolls have exceeded the maximum used for FICA tax.

D Allocation Basis - Report the salary, etc., from Column B, adjusted by the amounts in Column C.

E Percentage - Divide each line of Column D by the total of that column and record the percentage in this column. Round all percentages to the nearest hundredth of a percent.

F Adjustment - Multiply the percentage in Column E by the total FICA tax reported on Schedule B, Part 3, Line 35, and record the result in this column.

G Line Number to Adjust - The form includes the payroll tax line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

H Exemption - Report amounts in this column needed to adjust the salaries, etc., in Column B to an equitable allocation base for other payroll taxes.

I Allocation Basis - Report the salary, etc., from Column B, adjusted by the amounts in Column H.

J Percentage - Divide each line of Column I by the total of that column and record the percentage in this column.

K Adjustment - Multiply the percentage in Column J by the total other payroll tax reported on Schedule B, Part 3, Line 36, and record the result in this column.

L Line Number to Adjust - The form includes the payroll tax line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

M Percentage - Divide each line of Column B by the total of that column and record the percentage in this column.

N Adjustment - Multiply the percentage in Column M by the allowable benefits included on Schedule B, Part 3, Lines 37 through 43, and record the result in this column.

O Line Number to Adjust - The form includes the fringe benefits line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

THE TOTAL OF THE ADJUSTMENT COLUMNS MUST AGREE WITH THE CORRESPONDING AMOUNTS IN THE GENERAL COST CATEGORY ON SCHEDULE B, PART 3. NO REIMBURSEMENT IS COMPUTED FOR ANY COSTS REMAINING IN THE GENERAL COST CATEGORY.

Summarize the adjustments from this schedule, along with those from Schedules B-2, B-3, and B-4, in Column D of Schedule B, Part 3.

12-012.09L Schedule B-2, Transactions with Related Organizations, Report and Adjustments, Description: Schedule B-2, located on page 17 of the report form, is used to report ALL related organization transactions included in the operating and ancillary cost categories and to determine the related adjustments.

12-012.09M Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-2.

A Name of Related Organization or Individual - Report the name of the related organization or the individual.

B Percent of Ownership, Related Organization in Nursing Home - Report what portion of the provider is owned by the related organization.

C Percent of Ownership, Nursing Home in Related Organization - Report what portion of the related organization is owned by the provider.

D Common Owners, Percent Ownership in Nursing Home - Determine the individuals or organizations that have ownership in both the related organization and the provider. Report the total share of the provider owned by those individuals and organizations.

E Common Owners, Percent Ownership in Related Firm - Determine the individuals and organizations that have ownership in both the related organization and the provider. Report the total share of the related organization owned by those individuals and organizations.

F Purchases from Related Organization in the Amount Of - Report the total amount of the transactions with the related organization or individual. Complete one line for each line of Schedule B, Part 3 that includes related party transactions.

G Cost to Related Organization of Services/Items Purchased - Report the original cost to the related organization. If the related organization qualifies for the exception to the limitation, do not report the cost. Instead, write the word "exception" in this column.

H Amount to (Increase) Decrease - Subtract the amount in Column G from the amount in Column F and record the difference in this column. If the exception applies, report zero in this column.

I Line Number - Report the Schedule B, Part 3 line number where the adjustment applies. If there is no adjustment, report the line number from Schedule B, Part 3 that includes the transaction.

Summarize the adjustments from this schedule, along with those from Schedules B-1, B-3, and B-4, in Column D of Schedule B, Part 3.

Copies of this form may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 20.

12-012.09N Schedule B-3, Compensation of Owners, Directors and Other Related Parties, Report and Adjustment, Description: Schedule B-3, located on page 18 of the report form, is used to report ALL compensation paid to owners, directors, and other individuals related to owners or directors. Compensation includes salary, benefits, and services or items paid by the provider which are for the personal use of an individual. The schedule is used to adjust the compensation paid to owners, directors, and related parties to the amount for reimbursement.

12-012.09P Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-3.

A Name of Individual - Report the name of every owner, director, or related party who receives compensation from the provider. If the individual holds more than one position, that is, his/her compensation is reported in more than one payroll category on Schedule B, Part 3, use separate report lines on this schedule for each position.

B Position - Report the paid position the individual holds at the facility. Attach specific job descriptions for each position listed.

C Documented Percentage of 40 Hour Work Week - Report the average percentage of a 40 hour week that the individual has DOCUMENTED performance of the duties assigned to the position.

D Percentage Owned - If the individual owns a portion of the provider, report the percentage of ownership in this column. Also, note the relationship, board position, or other reason that the individual is listed on the schedule.

E Account - Record the account descriptions from Schedule B, Part 3 where the compensation is reported. Each line includes space to report five accounts. Three of the spaces relate to payroll, payroll tax, and fringe benefits. Two spaces are provided to report compensation paid in other forms, i.e., automobile, housing, supplies, meals, etc.

F Amount Per Trial Balance - Report the compensation amount reported on Schedule B, Part 3.

G Amount Allowable - Based on the documented services provided, report the reasonable amount of compensation to be allowed. The allowable compensation is the usual amount paid for similar positions at the facility or for similar positions outside the facility. The amounts in this column must not exceed the amounts in Column F for the position.

H Amount to Decrease Cost - Subtract the amount in Column G from the amount in Column F and record the difference in this column.

I Line Number - Report the Schedule B, Part 3, line number where the adjustment applies. If there is no adjustment, report the line number from Schedule B, Part 3, that includes the compensation.

Summarize the adjustments from this schedule, along with those from Schedule B-1, B-2, and B-4, in Column D of Schedule B, Part 3.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 20.

<u>12-012.09Q Schedule B-4, Other Cost Adjustments, Description</u>: Schedule B-4, located on pages 19 and 20 of the report form, is used to report cost adjustments needed to change the trial balance costs to the amounts allowable for reimbursement.

12-012.09R Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-4.

A Adjustment Descriptions - Adjustment descriptions are provided on the first page of the schedule. Lines 1 through 17 describe some of the common Medicaid reimbursement adjustments. Lines 18 through 23 describe the fixed cost adjustments determined on other schedules of the report. The descriptions for these six lines include a reference to the adjustment's source schedule.

On the second page of the schedule, the Adjustment Description column is blank. Use these lines to report any other adjustments, increases, decreases, or reclassifications needed to complete the process of revision of the trial balance to the allowable cost for allocation. (Report an adjustment description, not the account description.)

B Amount to Increase Cost - Report the adjustment amount in this column if it increases the reported cost.

C Amount to Decrease Cost - Report the adjustment amount in this column if it decreases the reported cost.

D Line Number to Adjust - Report the line number from Schedule B, Part 3, where the adjustment amount in Column B and/or C applies.

If a revenue offset has been used to adjust for an unallowable cost, and the revenue offset covers the cost incurred, that cost does not need to have an adjustment on this form.

Summarize the adjustments from this schedule, along with those from Schedules B-1, B-2, and B-3, in Column D of Schedule B, Part 3.

Copies of the second page of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 100.

12-012.09S Schedule B-5, Statistical Data For Allocations, Description: Schedule B-5, located on page 21 of the report form, is used to report the allocation bases used for the allocation of costs between the NF and other cost centers. The statistics and resulting percentages reported on this schedule are used to distribute the costs on Schedule B, Part 3, Columns G and H.

12-012.09T Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-5.

A Basis No. - The numbers in this column, 0 through 31, are of major importance in the report process. They are used to complete Column F on Schedule B, Part 3, for each line that has cost to allocate.

B Allocation Basis - This column describes the basis used for the allocation. Basis 0 indicates that the provider's records will identify the reported distribution, thus no allocation was necessary. Bases 1 and 3 indicate that 100% of the costs relate to one cost center; NF, or Other, respectively. Bases 4 through 9 are commonly used allocation bases but are not required to be used. The remaining lines are left for the provider to identify other allocation bases selected.

C Statistics for Allocation, Total - Report the total of the statistic base. Report the statistics on the top portion of each basis line. Report the percentage on the bottom portion of each basis line. For this column, the percentage is 100.00%.

D Statistics for Allocation; NF and Other - On the top portion of the basis line report the breakdown of the statistics used for allocation. Compute the percentage each cost center's statistics are of the total statistical base and record the percentage in the bottom portion of the basis line.

ROUND THE PERCENTAGES TO ONE HUNDREDTH OF A PERCENT.

If an allocation basis is more complex than the straight one line statistical basis, write "See Attachment ##" on the description line. Show the statistics and computations used to determine the allocation on the attachment. Record the percentages on both portions of the basis line of the form.

Do not use more bases than the blank lines permit.

Allocation bases used must be consistent from year to year unless a change is approved or directed by the Department.

All allocation bases must be approved by the Department before the Report Period.

12-012.10 Schedule C, Comparative Balance Sheet, Description: Schedule C, located on page 22 of the report form, is used to report the assets, liabilities, and equity of the provider. The schedule includes the prior year and current year information.

12-012.10A Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule C.

A Assets, Liabilities, and Equity - This column provides the account descriptions for the balance sheet accounts. Some lines have been left blank to add accounts not listed.

B Previous Year Ending - Record this column as it appears on the prior report period's cost report form. Note any variance from the prior year's report in the preparer's report.

C Current Year Ending - Report the current report period's closing balance sheet.

The reported data must reflect the provider's balance sheet. If the provider's balance sheet is part of a consolidation of several entities, the long term assets and liabilities must be reported for the provider with a balancing intercompany entry for equity. Beginning with the report period beginning July 1, 1986, the provider's portion of the balance sheet must be broken out from the consolidated statement and reported.

12-012.11 Schedule D, Part 1, Depreciation Cost, Description: Schedule D is a three-part schedule located on pages 23 and 24 of the report form.

Part 1, located on page 23 of the report form, is used to report the fixed assets recorded on the trial balance and summarize the adjustments needed to change the trial balance fixed asset cost to include only the nursing facility assets. It is also used to report the appropriate depreciation and to compute the adjustment to correct the trial balance depreciation.

The schedule includes summary data. The depreciation schedule maintained at the facility must provide the detail that identifies each fixed asset and the related depreciation.

12-012.11A Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule D.

A Description of Property - This column provides the identification of the asset groups to be reported. Several asset group titles are on the schedule. Other lines are blank for other groupings according to the trial balance.

B Date Acquired - Report the date that the property was acquired by the provider. This column only needs to be completed on the lines for the original assets.

C Trial Balance - Report the balance sheet cost amount for each of the asset groups. This column must agree with the balance sheet reported on Schedule C.

D Cost Adjustment - The adjustments reported on Schedule D-1 are summarized and reported in this column. The adjustments are considered a cost reduction unless the amount is recorded with brackets.

E Cost, Long Term Care Value - Subtract the cost adjustments in Column D from the trial balance amounts in Column C and record the difference in this column.

F Salvage Value - Report any salvage value expected at the end of the assigned useful life.

G Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight-line method.

H Useful Life - The useful lives assigned for reimbursement purposes must follow the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition (see 471 NAC 12-011.09). (IRS accelerated cost recovery system lives do not qualify for "depreciation" for Medicaid reimbursement purposes.) Report lives as years.

I Not used on this part of the schedule.

J Prior Years Depreciation - Report the accumulated depreciation as of the beginning of the report period. Report the amount based on Medicaid values.

K Depreciation Cost - Report the depreciation for the report period. Subtract the amount in Column F from the amount in Column E and divide the difference by the assigned life. For partial years, prorate the annual amount.

L Medicaid Book Value - The long term care cost value minus the accumulated Medicaid depreciation cost for the assets that remain in use at the end of the report period.

Transfer the cost of leased items from Schedule E, Part 1 to Line 27. Add amounts in each column and record the totals on Line 28. Transfer the depreciation cost from the trial balance to Line 29 of Column K. The trial balance depreciation cost is reported on Schedule B, Part 3, Column B, Line 233. In Column J, subtract the amount reported on Line 29 from the amount reported on Line 28 and record the difference on Line 30. Transfer this amount to Schedule B-4 as indicated on the form.

12-012.11B Schedule D, Part 2, Cost Report Period Additions, Description: Part 2, located on page 24 of the report form, is used to report the depreciation schedule information for fixed assets added during the report period.

12-012.11C Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by additional information about this part of Schedule D.

A Item Description - Report the specific description of the asset that has been added. This may not be reported in summary form except when identical assets are purchased in one lot on the same day. In such a case, include the number of items.

B Date Acquired - Report the date that the item was purchased or acquired.

C Not used in this part.

D Useful Life - Report the useful life used for Medicaid reimbursement purposes.

E Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight-line method.

F Original Cost - Report the asset cost included in Column E of Part 1 as a result of acquisition of the fixed asset.

G Salvage Value - Report any salvage value expected at the end of the assigned useful life.

H Current Year Depreciation Cost - Report the depreciation as computed for Medicaid purposes. Subtract the salvage value, Column G, from the original cost, Column F, and divide by the number of years useful life, Column D. For partial years, prorate the annual amount.

I Not used for this part.

J Schedule D, part 1, Line Number - Report the line number where the new addition is included on the Depreciation Schedule Summary, Schedule D, Part 1.

Add all amount columns and record the total on the total line.

Copies of this part of the schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the page.

FIXED ASSET ADDITIONS MUST BE REPORTED ON THIS PART OF THE SCHEDULE IN ORDER FOR DEPRECIATION TO BE ALLOWED.

12-012.11D Schedule D, Part 3, Current Report Period Deletions, Description: Part 3, located on page 24 of the report form, is used to report the depreciation schedule information for fixed assets removed from long term care during the report period.

12-012.11E Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by additional information about this part of Schedule D.

A Item Description - Report the specific description of the asset that has been removed from service. Each item must be identified separately.

B Date of Acquisition - Report the date the fixed asset was originally acquired.

C Date of Disposal - Report the date the item was no longer used for long term care.

D Useful Life - Use the American Hospital Association guidelines to determine useful lives.

E Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight line method.

F Original Cost - Report the asset cost used for Medicaid depreciation.

G Salvage Value - Report the amount that had been carried on the depreciation schedule as the salvage value.

H Current Year Depreciation Cost - Report the depreciation from the beginning of the report period to the date that the asset was no longer in use for long term care.

I Accumulated Depreciation - Report all depreciation which has accumulated from the date of acquisition to the date the time was removed from service for long term care.

J Schedule D Part 1 Line Number - Report the line number where the item removed will be deleted from the Depreciation Schedule Summary, Schedule D, Part 1.

Add all amount columns and record the totals on the total line.

FIXED ASSET DELETIONS MUST BE REPORTED ON THIS SCHEDULE IN ORDER FOR THE PAST DEPRECIATION TO BE ALLOWABLE.

Copies of this part of the schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the page.

12-012.12 Schedule D-1, Depreciation Schedule Adjustments, Description: Schedule D-1, located on page 25 of the report form, is used to itemize and describe the adjustments used to adjust the facility trial balance fixed asset cost to the amount allowed. It is also used to make adjustments to reclassify fixed asset categories.

12-012.12A Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule D-1.

A Adjustment Description - Report the reason for each adjustment. Do NOT report only the item description or property category to be adjusted.

B Amount to Increase Cost - Report the adjustment amount to increase the fixed asset cost on Schedule D, Part 1.

C Amount to Decrease Cost - Report the adjustment amount to decrease the fixed asset cost on Schedule D, Part 1.

D Schedule D Line to Adjust - For each adjustment increase and/or decrease reported in Columns B and C, report the line number on Schedule D, Part 1 that is to be adjusted.

After completing the adjustments, summarize the adjustments on Schedule D, Part 1, Column D.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule.

12-012.13 Schedule E, Interest Cost, Description: Schedule E is a two-part schedule located on pages 26 and 27 of the report form.

12-012.13A Schedule E, Part 1, Loans and Interest Cost Summary, Description: Part 1, located on page 26 of the report form, is used to report the loan information for all loans included on the trial balance and adjustments needed to change the trial balance to include only the allowable loans. It is also used to determine the adjustments necessary to adjust the trial balance interest cost to the amount allowable for reimbursement.

12-012.13B Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule E.

A Source/Security and Purpose - This column includes three items of information for each loan:

Source - Report the lending institution or individual who made the loan to the provider. If the loan is a bond issue, report the type of bond issue (i.e., revenue bonds, industrial development bonds, etc.).

Related Parties (X) - Mark this box if the source of the loan is related to the provider through common ownership or control as defined by the regulations.

Security and Purpose - Report the security pledged for repayment (i.e., mortgage, real property (describe), or personal property (describe), or as a "signature loan"). REPORT THE PURPOSE OF THE LOAN (i.e., to finance purchase of assets, to provide operating funds, to build an addition, to pay taxes, etc.). If additional space is needed to report the security and purpose, include the information on an attachment.

B Date of Origin/Date Mature - This column includes two items of information for each loan:

Date of Origin-Report the date the loan was obtained.
Date Mature-Report the date that the loan becomes due or the date the final installment is due.

C Original Loan Amount - Report the amount borrowed at the Date of Origin. If the loan has a floating balance such as a line of credit, report the highest balance for the report period.

D Interest Rate - Report the interest rate as specified in the conditions of the loan. In cases of variable interest loans, mark a "V" in the box at the left of the column and report the final rate effective for the report period.

E Adjusted Beginning Balance - Report the loan balances as they appeared on the prior year cost report "Adjusted Ending" column. If the loan originated during the report period, enter -0- in this column.

F Ending Loan Balance - Report the loan amount as they appear on the trial balance. If a loan was paid off during the report period, report -0- in this column.

G Adjustments - The loan balance adjustments reported on Schedule E-1 are summarized and reported in this column. The adjustments are considered a loan reduction unless the amount is recorded with brackets.

H Adjusted Ending - Subtract the amount in Column G from the amount in Column F and record the difference in this column.

I Not used on this part of the schedule.

J Interest Cost, Paid to Unrelated Parties - Report the allowable interest in this column. If the full interest amount for a loan is not allowable, report the allowable portion in this column. The unallowable portion is reported in Column L.

K Interest Cost, Paid to Related Parties - Report the interest paid and/or accrued on the loans from parties related to the provider by common ownership or control. The loan balance for these loans are included in the adjustments in Column G.

L Interest Cost, Non-Nursing Facility Operations - Report the interest paid and accrued on loans which are not related to the nursing facility. The loan balances for these loans are included in the adjustments recorded in Column G. Also report the unallowable portion of the interest cost for loans which are otherwise allowable.

Transfer the lease cost information from Schedule F, Part 1, to Line 10. Add the amount columns and record the totals on Line 11. Provide a breakdown of the loans, as indicated, for Lines 12, 13, and 14.

Transfer the totals of Columns K and L to Schedule B-4 as indicated on the form.

Copies of this form may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. If additional copies are used, record the total for ALL copies on the last copy. Do not complete Lines 10 through 14 except on the final copy.

Attach one copy of the signed loan agreement for all loans originated or refinanced during the Report Period.

12-012.13C Schedule E, Part 2, Interest Limitation Computation, Description: Part 2, located on page 27 of the report form, is used to compute the interest limitation required when interest bearing loans exceed 80% of the cost of the fixed assets used for patient care. Two options are available for the computation. Option 1 bases the limitation on the year end loan and asset balances. Option 2 bases the limitation on monthly balances. A provider may change from Option 1 to Option 2 for any report. After Option 2 is selected for any report period, it must be used for all subsequent reports, unless a change is approved by the Department.

Government-operated providers do not need to complete Part 2. They are not subject to the limitation. (Government operated providers MUST complete Part 1.)

12-012.13D Definitions: Definitions of the data requested on this part of Schedule E follow:

OPTION 1: ANNUAL AVERAGE - The definitions are given for each line.

1. Record the ending loan balance from Schedule E, Part 1. The line reference is indicated on the form.

2. Record the asset cost from Schedule D, Part 1. The line reference is indicated on the form.

3. If the asset cost was decreased because of a change of ownership on or after December 1, 1984, determine the amount of the adjustment which would otherwise be allowed. Record that amount on this line.

4. Add Line 2 to Line 3 and record the total on this line.

5. Multiply the amount on Line 4 by 0.80 and record the result on this line.

6. Subtract the amount on Line 5 from the amount on Line 1 and record the difference on this line. If the amount is zero or a negative amount, do not complete the remainder of the form. If it is a positive amount, continue with Line 7.

7. Record the beginning loan balance from Schedule E, Part 1. The line reference is indicated on the form.

8. Record the ending loan balance from Schedule E, Part 1. The line reference is indicated on the form. (This is the same as the amount on Line 1.)

9. Compute the average loan balance. Add the amount on Line 7 and the amount on Line 8 and divide the total by 2. Record the result on this line.

10. Record the interest paid to unrelated parties from Schedule E, Part 1. The line reference is indicated on the form.

11. Compute the average annual interest rate. Divide the amount on on Line 10 by the amount on Line 9. Record the result on this line.

12. Compute the amount of the limitation. Multiply the rate from Line 11 by the amount on Line 6. Transfer the limitation to the Schedule B-4 as indicated on the form.

OPTION 2 - MONTHLY AVERAGE - The definitions for the columns are followed by additional information about Option 2.

A Date - This column indicates the date that loan information and limitations are to be calculated. If the report is completed for less than the full 12 months, complete only the applicable months. Report the beginning amounts for a report period on Line 1, even if starting on another date. Write the correct beginning date on the line.

B Total All Interest Bearing Loans - Report the total loans that accrue interest.

C Total Related Party Interest Bearing Loans - Report the loans with related parties included in the amount reported in Column B.

D Total Non-Nursing Home Loans - Report the loans not related to the long term care which are included in Column B.

E Allowable Loan Balances - Add the amount in Column C to the amount in Column D. Subtract the total from the amount in Column B. Record the result in this column.

F Cost of Fixed Assets Related to Care - Report the total cost of fixed assets as determined for Medicaid reimbursement. When determining the asset cost for Medicaid reimbursement, do not consider fixed asset cost limitations that are solely the result of 471 NAC 12-011.06H and J.

G 80% of Asset Cost - Multiply the amount in Column F by 0.80 and record the result in this column.

H Loan Balance Over 80% of Asset Cost - Subtract the amount in Column G from the amount in Column E and record the difference in this column. IF THE RESULT IS NEGATIVE, REPORT -0-, NOT THE NEGATIVE AMOUNT.

I Average Interest Rate - Complete Lines 14 through 18 as follows:

14 Add amounts in each column and record the total on this line.

15 Compute the average monthly loan balance. Divide the amount from Column E, Line 14, by the number of dates reported. Record the result on this line in Column E. Also record the result on Line 17.

16 Record the interest paid to unrelated parties as determined on Schedule E, Part 1. The line reference is indicated on the form.

17 Record the amount from Column E, Line 15 on this line.

18 Compute the average rate of interest. Divide the amount on Line 16 by the amount on Line 17. Record the total on this line.

Record the average rate of interest from Line 18 on all lines of Column I.

J Interest Adjustment - Compute the interest limitation for the month. Multiple the amount in Column H by the rate in Column I. Divide the result by the number of months covered by the cost report and record the result in this column.

Add the amounts in Column J and record the total on Line 14. Also record the result on Schedule B-4 as indicated on the form.

Use of Option 2 requires the provider to maintain detailed accrual records on a monthly basis.

12-012.14 Schedule E-1, Loan Schedule Adjustments, Description: Schedule E-1, located on page 28 of the report form, is used to itemize and describe the adjustments used to adjust the ending loan balances to the amounts used for reimbursement.

12-012.14A Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule E-1.

A Adjustment Description - Report the reason for each adjustment in this column. Do NOT report only the loan source to be adjusted.

B Increase of Loan Amount - Report the adjustment amount to increase the loan amount on Schedule E, Part 1.

C Decrease of Loan Amount - Report the adjustment amount to decrease the loan amount on Schedule E, Part 1.

D Sch. E Part 1 Line to Adjust - For each adjustment increase and/or decrease reported in Columns B and C, report the line number from Schedule E, Part 1 which is to be adjusted.

After completing the adjustments, summarize the adjustments and record the totals on Schedule E, Part 1, Column G.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule.

12-012.15 Schedule F, Leases, Description: Schedule F is a two-part form located on pages 29 and 30 of the report form.

12-012.15A Schedule F, Part 1, Leases and Lease Adjustments, Description: Part 1, located on page 29 of the report form, is used to report information regarding all fixed long term leases included in the provider's fixed costs. The information reported on Line 5 determines if Part 2 and the remainder of the column is completed for any lease. This part also summarizes information from all copies of Part 2 and the resulting adjustments.

12-012.15B Definitions: Definitions of the data requested for this part of the schedule follow. Line definitions are followed by other information about this part of Schedule F.

1 Assigned Lease Number - Chronologically number the columns used to report on the leases. One column must be completed for each lease agreement.

2 Leasing Company or Individual - Report the name of the lessor as it appears on the lease agreement.

3 Items Leased - Describe the leased item or items. If the lease covers many items, use a summary description.

4 Cost Included on Trial Balance - Report the amount included in the lease costs reported on Schedule B, Part 3. (Do not report non-nursing facility leases. Such leases should be removed from the trial balance amount by adjustments on Schedule B-4.)

5 Mark the first line, 5a through 5e, that applies to the lease.

5a Related Organization - Mark the line if the lessor is related to the provider through common ownership or control as defined in the regulations.

5b Facility Leased after 7/31/82 - Mark this line if the lease agreement is subject to limitation according to 471 NAC 12-011.06E. The regulation refers to facilities leased after July 31, 1982.

5c Lease Purchases - Mark this line if the lease agreement is a lease/purchase agreement as defined in the Provider Reimbursement Manual HIM-15, Section 110.

5d Sale and Lease Back - Mark this line if the lease agreement involves a sale and lease back by the seller.

5e Other - Mark this line if 5a, 5b, 5c, and 5d do not apply to the lease.

If 5a, 5b, 5c, or 5d is marked, Part 2 must be completed for the lease. Part 2 must be completed before Lines 6 through 18 can be completed for the lease.

If line 5e is marked, do not complete Part 2 or lines 6 through 18.

Lines 6 through 18 summarize information on leases subject to ownership cost limitations. Develop the data for an individual lease by completing Part 2.

6 Cost to Reduce, Building and Perm. Equipment Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2, that is for building and permanent equipment.

7 Cost to Reduce, Vehicle Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2 that is for a vehicle.

8 Cost to Reduce, Other Long Term Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2 that is for other long term leases.

9 Cost to Allow, Depreciation - If the owner's cost is substituted for the lease, record the total depreciation amount from Part 2, Item 4.

10 Cost to Allow, Interest - If the owner's cost is substituted for the lease, record the total interest amount from Part 2, Item 5.

11-15 Cost to Allow, Other - If the owner's cost is substituted for the lease, record the other amounts by account description from Part 2, Item 6.

16 Other Ownership Data, Asset Cost - If owner's cost is substituted for the lease, record the total asset cost from Part 2, Item 4.

17 Other Ownership Data, Beginning Loan Balance - If owner's cost is substituted for the lease, record the total beginning balance from Part 2, Item 5.

18 Other Ownership Data, Ending Loan Balance - If owner's cost is substituted for the lease, record the total ending balance from Part 2, Item 5.

After completing all leases, add the amount lines and record the total in the last column of the last copy of Part 1. Also record the totals from Lines 6 through 18 on the other schedules as indicated at the end of each line on the form.

If any lease was originated, renegotiated, or otherwise changed during the Report Period, include one copy with the submitted reports.

This part of the schedule may be copied to expand the number of columns as needed. Record the copy number in the box at the bottom of the page.

12-012.15C Schedule F, Part 2, Ownership Cost, Description: Part 2, located on page 30 of the report form, is used to report information on each lease which may be subject to the ownership cost limitations. The use of this part depends on which item is marked on Schedule F, Part 1, Line 5. A short outline on the form indicates how to report the cost information for each of the four options. Complete this part for each lease marked on Schedule F, Part 1, Line 5a, 5b, 5c, or 5d. Copy the page as needed to report on subject leases.

12-012.15D Definitions: Definitions of the data requested for each item of this part of Schedule F follow.

1 Record the lease number assigned to this lease from Part 1, Line 1.

2 Record the cost reported for this lease. The amount will agree with the amount reported on Part 1, Line 4.

3 Complete only when 5b is marked on Part 1. Mark yes or no for each question. The three items are required for any cost to be allowed for a facility or facility/equipment lease entered into after July 31, 1982. If ANY of the questions are answered no, report -0- for all the totals in Items 4, 5, and 6. If ALL are answered yes, complete Items 4, 5, and 6.

4 Depreciation Schedule - Report the depreciation schedule data for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

5 Loans and Interest - Report the loan data for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

6 Other Costs - Report any other costs for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

Depending on the basis for completion of Part 2, transfer the totals and other amounts to Part 1, Lines 6 through 18.

12-012.16 Preparer Acknowledgement, Description: The preparer acknowledgement is located on the last page of the report form. This part must be completed by any person or firm that prepares the cost report. The acknowledgement, in and of itself, is not a "report" on the statements of the cost report. Reports issued by the preparer are part of the cost report and must be attached to the cost report.

The preparer of a cost report must be familiar with the Nebraska Medicaid reimbursement program and the long term care industry accounting principles and practices. The preparer must discuss potential disallowances with the provider's management. The preparer must, in the preparer's report, disclose known variances from the reporting and regulatory requirements included in the cost report preparation.

Instructions: Record the following information in the blanks:

- the "official" name of the provider organization, the name that appears on the current Nebraska Medicaid Provider Agreement.

- the provider number assigned by the Department.

If the preparer is a certified public accountant or accounting firm, indicate the type of report issued on the engagement.

Signature - The preparer signs the acknowledgement. Also print or type the name of the individual signing the acknowledgement.

Firm - Report the name of the firm contracted to prepare the report.

Date - Report the date the acknowledgement is signed.

12-012.17 Certification of Officer, Owner, or Administrator, Description: The certification is located on the last page of the report form. It is used by the provider's management to attest to the accuracy of the cost report information provided to the Department. The person signing the report must be familiar with the Nebraska Medicaid Program's reimbursement regulations and the provider's costs. The person signing the report indicates by signature, that she/he has reason to know what is included in the report and what cannot be included in the report.

Instructions: Record the following information in the blanks:

- the "official" name of the long term care provider organization, the name that appears on the current Nebraska Medicaid Provider Agreement.

- the provider number assigned by the Department.

- the beginning and ending date of the period covered by the cost report.

Signature - The provider's owner, officer, or administrator signs the report. Also type or print the name in this box.

Title - Report the title of the individual signing the report.

Date - Report the date the report is signed.

12-013 Classification of Residents and Corresponding Weights

12-013.01 Resident Level of Care: The Department will use a federally-approved Resource Utilization Groups (RUG) grouper to assign each resident to a level of care based on information contained on his/her Minimum Data Set (MDS) assessment. Each level of care will be assigned the federally-recommended weight (see 471 NAC 12-013.04). When no MDS assessment is available, the resident will be assigned to a default level of care (Level 180).

12-013.02 Weighting of Resident Days Using Resident Level of Care and Weights: Each facility resident is assigned to a level of care per 471 NAC 12-013.01. Each resident's level of care is appropriately updated from each assessment to the next – the admission assessment, a significant change assessment, the quarterly review, the annual assessment, etc., and is effective for payment purposes on the first day of the month of the applicable assessment if it is received by the tenth day of the month of the applicable assessment. A change in resident level of care which results from an audit of assessments (see 471 NAC 12-013.05) is retroactive to the effective date of the assessment which is audited.

For purposes of the Nebraska Medicaid Case Mix System, the Department does not change an assessment record. A record modification may replace an existing record in the Centers for Medicare and Medicaid Services (CMS) MDS data base, but the Department will not replace the existing record in the Nebraska Medicaid Case Mix system. The record modification will be processed by the Department as an original record. This means that the Department will process the record in the usual manner if the record is not already in the Case Mix system. The Department will reject the record as a duplicate if the record has already been accepted into the Case Mix system. The Department will inactivate a discharge or re-entry tracking record but not an assessment.

For each reporting period, the total resident days (per the MDS system) at each care level are multiplied by the corresponding weight (see 471 NAC 12-013.03). The resulting products are summed to determine the total weighted resident days per the MDS system. This total is then divided by the MDS total resident days and multiplied by total resident days per the facility's Nebraska Medicaid Cost Report to determine the total number of Weighted Resident Days for the facility, which is the divisor for the Direct Nursing Component.

12-013.03 Resident Level of Care Weights: The following weighting factors shall be assigned to each resident level of care, based on the CMS RUG III 5.20 version.

Level Of Care	Casemix Index Value	Casemix Index Description	Casemix Index Value
163	RAD	Rehabilitation/ADL = 17-18	1.66
162	RAC	Rehabilitation/ADL = 14-16	1.31
161	RAB	Rehabilitation/ADL = 9-13	1.24
160	RAA	Rehabilitation/ADL = 4-8	1.07
172	SE3	Extensive Services 3/ADL >6	2.10
171	SE2	Extensive Services 2/ADL >6	1.79
170	SE1	Extensive Services 1/ADL >6	1.54
152	SSC	Special Care/ADL = 17-18	1.44
151	SSB	Special Care/ADL = 15-16	1.33
150	SSZ	Special Care/ADL = 4-14	1.28
145	CC2	Clinically Complex w/Depression/ADL = 17-18	1.42
144	CC1	Clinically Complex/ADL = 17-18	1.25
143	CB2	Clinically Complex w/ Depression/ADL = 12-16	1.15
142	CB1	Clinically Complex/ADL = 12-16	1.07
141	CA2	Clinically Complex w/Depression/ADL = 4-11	1.06
140	CA1	Clinically Complex/ADL = 4-11	0.95
133	IB2	Cognitive Impairment with Nursing Rehab/ADL = 6-10	0.88
132	IB1	Cognitive Impairment/ADL = 6-10	0.85
131	IA2	Cognitive Impairment with Nursing Rehab/ADL = 4-5	0.72
130	IA1	Cognitive Impairment/ADL = 4-5	0.67
123	BB2	Behavior Prob w/Nursing Rehab/ADL = 6-10	0.86
122	BB1	Behavior Prob/ADL = 6-10	0.82
121	BA2	Behavior Prob w/Nursing Rehab/ADL = 4-5	0.71
120	BA1	Behavior Prob/ADL = 4-5	0.60
115	PE2	Physical Function w/Nursing Rehab/ADL = 16-18	1.00
114	PE1	Physical Function/ADL = 16-18	0.97
113	PD2	Physical Function w/Nursing Rehab/ADL = 11-15	0.91
112	PD1	Physical Function/ADL = 11-15	0.89
111	PC2	Physical Function w/Nursing Rehab/ADL = 9-10	0.83
110	PC1	Physical Function/ADL = 9-10	0.81
Medicaid Waiver Assisted Living Levels of Care			
104	PB2	Physical Function w/Nursing Rehab/ADL = 6-8	0.65
103	PB1	Physical Function/ADL = 6-8	0.63
102	PA2	Physical Function w/Nursing Rehab/ADL = 4-5	0.62
101	PA1	Physical Function/ADL = 4-5	0.59
Default Rate – Used When No Assessment is Available			
180	STS	Short Term Stay	0.59

*Level of Care 180 (Short-term stay) is used for stays of less than 14 days when a client is discharged and the facility does not complete a full MDS admission assessment of the client. This is effective for admissions on or after July 1, 2010.

12-013.04 Verification: Resident assessment information is audited as a procedure in the Department of Health and Human Services Division of Public Health Survey and Certification process.

12-014 Services for Long Term Care Clients with Special Needs

12-014.01 The term "Long term care clients with special needs" means those whose medical/nursing needs are complex or intensive and are above the usual level of capabilities of staff and exceed services ordinarily provided in a nursing facility as defined in 471 NAC 12-003.

12-014.01A Ventilator-Dependent Clients: These clients are dependent on mechanical ventilation to continue life and require intensive or complex medical services on an on-going basis. The facility shall provide 24-hour R.N. nursing coverage.

12-014.01A1 Criteria for Care: The client must -

1. Require intermittent (but not less than 10 hours in a 24-hour period) or continuous ventilator support. S/he is dependent on mechanical ventilation to sustain life, or is in the process of being weaned from mechanical ventilation (this does not include individuals using continuous positive airway pressure (C-PAP) or Bi-level positive airway pressure (BiPAP) nasally; patients requiring use of Bi-PAP via a tracheostomy will be considered on a case-by-case basis);
2. Be medically stable and not require intensive acute care services;
3. Have care needs which require multi-disciplinary care (physician, nursing, respiratory therapist, psychology, occupational therapy, physical therapy, pharmacy, speech therapy, spiritual care, or specialty disciplines);
4. Require daily respiratory therapy intervention and/or modality support (for example: oxygen therapy, tracheostomy care, chest physiotherapy, deep suctioning, etc.); and
5. Have needs that cannot be met at a lesser level of care (for example: skilled nursing facility, regular nursing facility unit, assisted living, private home).

12-014.01B Clients with Brain Injury:

12-014.01B1 Clients Requiring Specialized Extended Brain Injury Rehabilitation: These clients must require and be capable of participating in an extended rehabilitation program. Their care must be -

1. Primarily due to a diagnosis of acute brain injury (see 471 NAC 12-001.04); or
2. Primarily due to a diagnosis of chronic brain injury following demonstration of significant improvement over a period of six months while receiving rehabilitative services based on approval by NMAP.

12-014.01B1a Criteria for Care: The client must:

1. Require physician services that exceed those described in 471 NAC 12-007.09;

2. Have needs that exceed the nursing facility level of care (that is, needs that cannot be met at a lower level of care such as a traditional nursing facility, assisted living, or a private home), as evidenced by:
   a. Complex medical needs as well as extended training or rehabilitation needs that together exceed the criteria for nursing facility level of care;
   b. Combinations of extended training or rehabilitative needs that together exceed the criteria for nursing facility level of care;
   c. Extended training or rehabilitation needs that require multi-disciplinary care including but not limited to those provided by a psychologist, physician, nurse, occupational therapist, physical therapist, speech and language pathologist, cognitive specialist, rehabilitation trainer, etc.; or
   d. Complex combinations of needs from various domains such as behavior, cognitive, medical, emotional and physical.
3. Be capable of participating in an extended training or rehabilitation program evidenced by:
   a. Ability to tolerate a full rehabilitation schedule daily;
   b. Being medically stable and free from complicating acute major medical conditions that would prohibit participation in an extended rehabilitation program;
   c. Possessing the cognitive ability to communicate some basic needs, either verbally or non-verbally;
   d. Being able to respond to simple requests with reasonable consistency, not be a danger to themselves or others, but may be confused, inappropriate, engage in non-purposeful behavior in the absence of external structure, exhibit mild agitation, or have severe attention, initiation, and/or memory impairment (minimum Level IV on the Rancho Los Amigos Coma Scale; and
   e. Being absent of addictive habits and/or behaviors that would inhibit successful participation in the training or rehabilitation program;
4. Have potential to benefit from an extended training or rehabilitation program resulting in reduced care needs, increased independence, and a reasonable quality of life as evidenced by:
   a. Possessing a current documented prognosis that indicates that s/he has the potential to successfully complete an extended training or rehabilitation program;
   b. Possessing the ability to learn compensatory strategies for, or to acquire skills of daily living in areas including, but not limited to transportation, money management, aide management, self medication, social skills, or other self cares which may result in requiring residency in a lower level of residential care; and
   c. Documentation supporting that s/he is making continuous progress in an extended training or rehabilitation program including transitional training for successful discharge or transfer.

12-014.01B2 Criteria for Care of Clients Requiring Long Term Care Services for Brain Injury: The client must:

1. Have needs that exceed the nursing facility level of care (that is, needs cannot be met at a lower level of care such as traditional nursing facility, assisted living, or a private home), as evidenced by:
   a. Combinations of medical, care and/or rehabilitative needs that together exceed the criteria for nursing facility level of care;
   b. Care that requires a specially trained, multi-disciplinary team including but not limited to physician, nurse, occupational therapist, physical therapist, speech and language pathologist, psychologist, cognitive specialist, adaptive technologist, etc.;
   c. Complex care needs occurring in combinations from various domains such as behavior, cognitive, medical, emotional, and physical that must be addressed simultaneously; or
   d. Undetermined potential to benefit from extended training and rehabilitation program;
2. Be capable of participating in clinical program as evidenced by:
   a. Being non-aggressive and non-agitated;
   b. Being absent of addictive habits and/or behaviors that would inhibit participation in clinical program;
3. Have potential to benefit from clinical program as evidenced by:
   a. Being cognitively aware of surroundings and/or events;
   b. Being able to tolerate open and stimulating environment;
   c. Being able to establish/tolerate routines;
   d. Being able to communicate verbally or non-verbally basic needs; and
   e. Requiring moderate to extensive assistance to preserve acquired skills.

12-014.01C Other Special Needs Clients: These clients must require complex medical/rehabilitative care in combinations that exceed the requirements of the nursing facility level of care. These clients may also use excessive amounts of supplies, equipment, and/or therapies. The client must meet the criteria for one of the two following categories:

12-014.01C1 Criteria for Care of Clients with Rehabilitative Special Needs: The client must -

1. Be medically stable and require physician services two - three times per week;
2. Require multi-disciplinary care (for example, physician, nursing, psychology, respiratory therapy, occupational therapy, physical therapy, speech therapy, pharmacy, spiritual care, or specialty disciplines);
3. Require care in multiple body organ systems;

4. Require a complicated medical/treatment regimen, requiring observation and intervention by specially trained professionals, such as:
   a. Multiple stage 2, or at least one stage 3 or stage 4 decubiti with other complex needs;
   b. Multiple complex intravenous fluids, or nutrition with other complex needs;
   c. Tracheostomy within the past 30 day with other complex care needs;
   d. Intermittent ventilator use (less than ten hours in a 24-hour period) with other complex care needs;
   e. Respiratory therapy treatments/interventions more frequently than every six hours with other complex care needs;
   f. Initiation of Continuous Abdominal Peritoneal Dialysis (CAPD) or established CAPD requiring five or more exchanges per day with other complex care needs; or
   g. In room hemodialysis as required by a physician with other complex care needs;
5. Require extensive use of supplies and/or equipment;
6. Have professional documentation supporting that s/he is making continuous progress in the rehabilitation program beyond maintenance goals; and
7. Have care needs that cannot be met at a lesser level of care (for example, skilled nursing facility, nursing facility, assisted living, or private home).

<u>12-014.01C2 Criteria for Care of Pediatric Clients with Special Needs</u>: The client must-

1. Be under age 21;
2. Be medically stable;
3. Require multidisciplinary care (physician, nursing, respiratory therapy, occupational therapy, physical therapy, psychology, or specialty disciplines); and
4. Require a complex medical/treatment regimen requiring observation and intervention by specially trained professionals, such as:
   a. Tracheostomy care/intervention with other complex needs;
   b. Intermittent ventilator use (less than ten hours in a 24-hour period) with other complex needs;
   c. Respiratory therapy treatments/interventions more than every six hours with other complex care needs; or
   d. Multiple complex care needs that in combination exceed care needs usually provided in a nursing facility (for example, variable gastrostomy/nasogastric/jejunostomy feedings with documented aspiration risk; complicated medication regimen requiring titration of meds and/or frequent lab monitoring to determine dosage; multiple skilled nursing services such as intermittent urinary catheterizations, sterile dressing changes, strict intake/output monitoring, intravenous medications, hyperalimentation or other special treatments).

12-014.01D: The revised admission criteria does not apply to clients admitted before the effective date of these regulations.

12-014.01E Exception: Under extenuating circumstances, the Director of Finance and Support may approve an exception to the criteria for care of long term care clients with special needs based on recommendations of HHSS staff.

12-014.02 Facility Qualifications: To be approved as a provider of services for LTC clients with special needs, a Nebraska facility providing services to special needs clients must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure as a hospital or a nursing facility and be certified to ~~in~~ participate in the Nebraska Medical Assistance Program (42 CFR 483, Subpart B). Out-of-state facilities must meet licensure and certification requirements of that state's survey agency. Out-of-state placement of clients will only be considered when their special needs services are not available within the State of Nebraska (see 471 NAC 1-002.02G).

The facility must demonstrate the capacity/capability to provide highly skilled multi-disciplinary care. The facility must ensure that its professional nursing staff have received appropriate training and have experience in the area of care pertinent to the individual client's special needs (such as ventilator dependent). The facility must have the ability to provide the necessary professional services as the client requires (such as respiratory care available 24 hours per day, seven days a week).

The facility must –

1. Demonstrate the capability to provide highly skilled multidisciplinary care;
2. Ensure that its staff have received appropriate training and are competent to care for the identified special needs population that is being served (for example, ventilator dependent, brain injury, complex medical/rehabilitation, complex medical pediatrics,);
3. Be able to provide the necessary professional services that the special needs clients require (for example, respiratory therapy 24 hours a day, 7 days a week);
4. Have the physical plant adaptations necessary to meet the client’s special needs (for example, emergency electrical back-up systems);
5. Establish admission criteria and discharge plans specific to each special needs population being served;
6. Have a separate and distinct unit for the special needs program;
7. Establish written special program criteria with policy and procedures to meet the needs of an identified special needs group as defined in 471 NAC 12-014.01;
8. Have written policies specific to the special needs unit regarding:
   a. Emergency resuscitation;
   b. Fire and natural disaster procedures;
   c. Emergency electrical back-up systems;
   d. Equipment failure (e.g.: ventilator malfunction);
   e. Routine and emergency laboratory and/or radiology services; and
   f. Emergency transportation.

9. Maintain the following documentation for special needs clients:
   a. A comprehensive multidisciplinary and individualized assessment of the client's needs before admission. The client's needs dictate which disciplines are involved with the assessment process. The assessment must include written identification of the client's needs that qualify the client for the special program as defined in 471 NAC 12-014.01. The initial assessment and the team's review and decisions for care must be retained in the client's permanent record. (see 471 NAC 12-014.03A);
   b. A copy of the admission "MDS 2.0 Basic Assessment Tracking Form" (Minimum Data Set), and Form DPI-OBRA1, "Identification Screen". These are to be maintained as part of the client's permanent record;
   c. A minimum of daily documentation or assessment and/or intervention by a Registered Nurse or other professional staff as dictated by the client's needs (e.g., Respiratory Therapy, Occupational or Physical therapy);
   d. A record of physician's visits; and
   e. A record of interdisciplinary team meetings to evaluate the client's response and success toward achieving the identified program goals and the team's revisions/additions/deletions to the established program plan (see 471 NAC 12-014.03D);
10. Maintain financial records in accordance with 471 NAC 12-011 and 12-012; and
11. Provide support services necessary to meet the care needs of each individual client and these must be provided under existing contracts or by facility staff as required by Medicare/Medicaid (42 CFR 483, Subpart B) for nursing facility certification (for example, respiratory, speech, physical or occupational therapies, psychiatric or social services).

12-014.03 Approval Process: NMAP pays for a special need nursing facility service as defined in 471 NAC 12-014 when prior authorized by the designated program specialist in the Central Office. Each admission shall be individually prior authorized.

12-014.03A Prior to Admission: A written comprehensive and individualized assessment completed by the facility must be sent to the Central Office. The assessment and accompanying documentation must address how the client meets the criteria for special needs care as defined in 471 NAC 12-014.01. It is the facility's responsibility to assess, gather and obtain this information and submit it to the Central Office for prior authorization and before admission.

Initial approval/denial will be given after Medicaid staff reviews the submitted information. It is the facility's responsibility to obtain and provide any missing or additional information requested by the Central Office. The initial approval will be delayed until all information is received by the Central Office staff. The Pre-Admission Screening Level I Evaluation (see 471 NAC 12-004.04) and Level II Evaluation, when applicable (see 471 NAC 12-004.08), must be completed before admission and the Level II findings/reports must accompany the packet of information sent to the Central Office for funding authorization.

12-014.03A1 Facilities serving the needs of individuals who are ventilator-dependent and other special needs clients (see 471 NAC 12-014.01A and 12-014.01C) must include the individualized admission assessment completed by the facility and other documentation which must include but is not limited to:

1. Current medical information that documents the client's current care needs;
2. Historical information that impacts the client's care needs;
3. Discharge summary(ies) of any facility stay(s) within the past 6 months;
4. Current physical/cognitive/behavioral status;
5. Justification for special needs level of care; and
6. Identification of major areas of preliminary care planning (an estimate of services needed to reach the proposed goals).

12-014.03A2 Facilities serving the needs of clients with brain injuries (see 471 NAC 12-014.01B) shall submit the individualized admission assessment completed by the facility and the following documentation which must include but is not limited to:

1. Current medical information that documents the client's current care needs, including a letter from the client's primary care physician indicating the potential for successful rehabilitation;
2. Historical information that impacts the client's care needs;
3. Discharge summaries of any facility stay(s) within the past year;
4. All discharge/service summaries of any rehabilitative (inpatient and outpatient) services received since the qualifying injury;
5. An Individualized Educational Plan (IEP) of any client under age 21 if one exists;
6. An Individual Program Plan and discharge statement/meeting for any client receiving or who has received services from the Developmental Disabilities System since the qualifying injury;
7. The written plan from Vocational Rehabilitative services if the client is receiving or has received since the qualifying injury;
8. Current physical/cognitive/behavior status; and
9. Identification of major areas of preliminary care planning (an estimate of services needed to reach the proposed goals).

12-014.03B Initial Approval: Based on the pre-admission assessment, initial approval/denial will be given by the Central Office staff for a 90-day admission, for assessment and development of a special needs plan of care. During this 90-day period, the individual will be receiving special needs care for the purposes of determining the potential for benefit from longer-term participation in the special needs program. At the end of 30 days, the Central Office will be provided a special needs formal plan of care, developed by the full interdisciplinary team. By the end of the 60th day, a report will be provided to the Central Office establishing demonstrated potential to benefit from the additional special needs programming, and estimating the time needed to complete the special needs plan of care, or recommendations to a lesser level of care.

12-014.03B1 In-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined facility staff shall (see 471 NAC 12-007)-

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.02C (the facility is responsible for verifying the client's Medicaid eligibility before completion of the MC9-NF) or submit electronically the standard Health Care Services Review Request for Review and Response transaction (ASC X12N 278);
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form DPI-OBRA1; and
4. Submit all information to the Central Office.

Facility staff must make a comprehensive assessment of the resident's needs within 14 days of admission, using the Minimum Date Set (MDS)2.0, and transmit it electronically to the Central Office in accordance with 42 CFR 483.20.

The HHSS review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time-limited.

12-014.03B2 Out-of-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined, facility staff shall (see 471 NAC 12-007)-

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C (the facility is responsible for verifying the client's Medicaid eligibility prior to completion of the MC9-NF) or submit electronically the standard Health Care Services Review Request for Review and Response transaction (ASC X12N 278);
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form DPI-OBRA1 (where applicable);
4. Attach a copy of their state-approved MDS; and
5. Submit all information to the Central Office.

The HHSS review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time-limited.

12-014.04 Utilization Review: The Department will review records and programs established for authorized Medicaid client stays in a Special Needs program on a quarterly basis. These reviews can be conducted on-site or by submitting requested documentation to the Department. Upon completion of a review, Department staff may determine that a client no longer meets the criteria as established in 471 NAC 12-014.01. The Department will notify the facility in writing of this finding. Examples of conditions for termination of special needs payment include but are not limited to:

1. The client has medically, physically, or psychologically regressed and cannot participate in the established program documented for at least one month duration;
2. The client refuses to participate in the established program for a documented time of at least one month;
3. The client no longer has documented progress toward established program goals and/or the client's progress has reached a plateau with no documented progress for at least three months (maintenance goals do not qualify the client to continue the program);
4. The client no longer meets criteria as defined in 471 NAC 12-014 that pertains to his/her specific program needs (for example, ventilator use, complex care needs are resolved, pediatric client turns 22).

12-014.04A Comprehensive Plan of Care: The facility must submit copies of the initial comprehensive plan of care and subsequent interdisciplinary team meetings (see 471 NAC 12-014.02, item 9e) that document the client's progress/lack of progress toward the client's established program outcomes/goals to the Medicaid Central Office quarterly.

12-014.04B: NMAP will require monthly reviews for extended brain injury rehabilitation stays beyond two years.

12-014.04C Right to Contest a Decision: See 471 NAC 2-003.01.

12-014.05 Payment for Services for Long Term Care Clients with Special Needs: Payment for services to all special needs clients must be prior authorized by Department staff in the Central Office.

12-014.05A Nebraska Facilities: To establish a Nebraska facility's payment rate for care of special needs clients:

1. The facility must submit Form FA-66,"Long Term Care Cost Report," to the Department for each fiscal year ending June 30. Medicare cost reporting forms may be substituted when Form FA-66 is not otherwise required to be submitted. Form FA-66 must be completed in accordance with 471 NAC 12-012, Completion of Form FA-66, "Long Term Care Cost Report," and 471 NAC 12-011 ff., Rates for Nursing Facility Services, as applicable. Medicare cost reports must be completed in accordance with Medicare's Provider Reimbursement Manual (HIM-15). If the facility provides both nursing facility services and special needs services, direct accounting and/or cost allocations necessary to distribute costs between the nursing facility and the special needs unit must be approved by the Department of Health and Human Services, Long Term Care Audit Unit.

2. The Department shall compute the allowable cost per day from the most recent State fiscal year Form FA-66 or the most recent Medicare cost report, as applicable, which will be the basis from which a prospective rate is negotiated. Payment for fixed costs is limited to the lower of the individual facility's fixed cost per diem or a maximum per diem of $54.00 excluding personal property and real estate taxes. Negotiations may include, but are not limited to, discussion of appropriate inflation/deflation expectations for the rate period and significant increases/decreases in the cost of providing services that are not reflected in the applicable cost report. The cost of services generally included in the allowable per diem include, but are not limited to:

   a. Room and board;
   b. Preadmission and admission assessments;
   c. All direct and indirect nursing services;
   d. All nursing supplies, to include trach tube and related trach care supplies, catheters, etc.;
   e. All routine equipment, to include suction machine, IV poles, etc.;
   f. Oxygen and related supplies;
   g. Psychosocial services;
   h. Therapeutic recreational services;
   j. Administrative costs;
   k. Plant operations;
   l. Laundry and linen supplies;
   m. Dietary services, to include tube feeding supplies and pumps;
   n. Housekeeping; and
   o. Medical records.

   Services not commonly included in the per diem (unless specifically provided via the facility's contract) include, but are not limited to:

   a. Speech therapy;
   b. Occupational therapy;
   c. Physical therapy;
   d. Pharmacy;
   e. Audiological services;
   f. Laboratory services;
   g. X-ray services;
   h. Physician services; and
   j. Dental services;

   These services are reimbursed under the Department's established guidelines. Costs of services and items which are covered under Medicare Part B for Medicare-eligible clients must be identified as an unallowable cost.

3. If the facility has no prior cost experience in providing special needs services, the facility must submit a budget for the provision of the intended service. The Department must concur that the budgeted cost per day meets a reasonable expectation of the cost of providing said service, taking into account the cost per day of similar facilities providing similar services. Budgets will be used until the facility has at least six months of actual cost experience.

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 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: The Level 105 rate, as defined in 471 NAC 12-011.08F, will be used as a basis for payment of hospitalization and/or therapeutic leave 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.

This level of care is highly skilled, provided by professionals in amounts not normally available in a skilled nursing facility, but available in the hospital. Lack of these services would normally result in continued hospitalization/institutionalization of these children. The cost of in-home services must be less than the cost of hospitalization.

The child must meet one of the following definitions to qualify for the Katie Beckett program:

1. Ventilator-Dependent Clients: These clients are ventilator-dependent and require intensive medical services/continual observation on an on-going basis.
2. Pulmonary Clients: These clients must require complex respiratory/medical care, e.g., tracheostomy, intensive IPPB treatments, etc., in combinations which exceed the needs of the skilled nursing client. These clients may also use excessive amounts of supplies and equipment.
3. Other Special Needs Clients: The clients must require complex medical/rehabilitative care in combinations, which exceed the requirements of the skilled nursing client. These clients may also use excessive amounts of supplies, equipment, and/or therapies.

Central Office approval for this level of care is required.

12-014.08 INTERMEDIATE SPECIALIZED SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

12-014.08A Introduction: The Nebraska Medical Assistance Program (NMAP) covers "intermediate specialized services (ISS) for persons with serious mental illness". ISS are covered for those individuals who have been identified by the Level II Preadmission Screening Process (PASP) evaluation and through the ISS evaluation process as needing services to maintain or improve their behavioral or functional levels above and beyond services that nursing facilities normally provide, but who do not require the continuous and aggressive implementation of an individualized plan of care, as "specialized services" is defined by PASP regulations in 471 NAC 12-004. These individuals need more support than nursing facilities would normally provide, but not at a "specialized services" level.

12-014.08B The requirements of 471 NAC 12 apply to ISS provided under 471 NAC 12-014.08 thru 12-014.08M unless otherwise specified.

12-014.08C Definition: Intermediate Specialized Services (ISS) for Individuals with Serious Mental Illness means services necessary to prevent avoidable physical and mental deterioration and to assist clients in obtaining or maintaining their highest practicable level of functional and psycho-social well being. Services are characterized by:

1. The client's regular participation, in accordance with his/her comprehensive care plan, in professionally developed and supervised activities, experiences, and therapies;
2. Activities, experiences, and therapies that reduce the client's psychiatric and behavioral symptoms, improve the level of independent functioning, and achieve a functional level that permits reduction in the need for intensive mental health services.

12-014.08D Program Components: ISS is designed to:

1. Provide and develop the necessary services and supports to enable clients to reside successfully in a nursing facility without the need of more intensive specialized services;
2. Maximize the client's participation in community activity opportunities, and improve or maintain daily living skills and quality of life;
3. Facilitate communication and coordination between any providers that serve the same client;

4. Decrease the frequency and duration of hospitalization and inpatient mental health (MH) services;
5. Provide client advocacy, ensure continuity of care, support clients in time of crisis, provide and procure skill training, ensure the acquisition of necessary resources, and assist the client in achieving social integration;
6. Expand the individual's comprehensive care plan to assure that it includes interventions to address: community living skills, daily living skills, interpersonal skills, psychiatric emergency and relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related areas necessary for successful living in the community;
7. Provide the individualized support and rehabilitative interventions as identified through the comprehensive care planning process to address client needs in the areas of: community living skills, daily living skills, interpersonal skills, psychiatric emergency and relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related services necessary for successful living in the community;
8. Monitor client progress in the services being received and facilitate revision to the comprehensive care plan as needed;
9. Provide therapeutic support and intervention to the client in time of crisis and, if hospitalization is necessary, facilitate, in cooperation with the inpatient treatment provider, the client's transition back into the client's place of residence upon discharge;
10. Establish hours of service delivery that ensure program staff are accessible and responsive to the needs of the client, including scheduled services that include evening and weekend hours; and
11. Provide or otherwise demonstrate that each client has on call access to a mental health provider on a 24 hour, 7 days per week basis.

<u>12-014.08E Criteria for ISS:</u> For ISS, the client must have been evaluated through the PASP process and the ISS evaluation process, and been determined to not need specialized services based on the outcomes of the Level II evaluation and the ISS Evaluation Process. The ISS Evaluation Process must include, but is not limited to, evaluation by a team which must consider an individual's long term residence in a mental health facility, higher levels of aggression, and higher levels of medical need. The client must be currently diagnosed with a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of DSM or ICD-9-CM equivalent (and subsequent revisions) except DSM "V" codes, substance use disorders, developmental disorders, and dementia which are excluded, unless they co-occur with another diagnosable serious mental illness.

12-014.08F Comprehensive Care Plan Development: The Department or its designee will refer clients authorized for ISS to the most appropriate provider(s), consistent with client choice. The ISS provider must work with the client to complete a comprehensive care plan that includes:

1. An assessment of the client's strengths and needs in that service domain according to the requirements of the Level II evaluation found at 471 NAC 12-004.09 and 12-004.13C and the ISS evaluation process; and
2. The Resident Assessment in accordance with 471 NAC 12-007.06 and 12-007.07.

12-014.08G Movement Between Specialized Services, ISS, and Regular Nursing Facility Services: Individuals' needs change over time and level of service intensity must change to appropriately meet those needs. Nursing facility staff and other service providers must identify changes in level of need as they occur. Such changes would include a decline in psychiatric stability that requires specialized services or marked decrease in the need for ISS. See 471 NAC 12-004.02.

12-014.08G1 Increase in Service Needs: Nursing facility staff must request review by the consulting psychiatrist when ISS are not sufficient to meet a client's needs (i.e., escalation in behavioral challenges, marked decreases in functional level, decreases in mental stability that might require inpatient stays). Based on the findings of the consulting psychiatrist, the client may be moved to an inpatient facility for receipt of specialized services.

12-014.08G1a Returning from Receiving Specialized Services for Mental Illness: For ISS clients, this process must follow procedures at 471 NAC 12-004.09A and 12-014.08E.

12-014.08G2 Decrease in Service Needs: When the need for ISS decreases, regular services that the nursing facility would normally provide may be sufficient. In addition to the normal discharge planning process under 471 NAC 12-007.19, ISS facility staff must request review by the ISS evaluation team. With the team's approval, the client may be transferred to regular nursing facility services.

12-014.08H Transfers: For ISS clients, transfers between nursing facilities will not require a Level I or Level II PASARRP evaluation. See 471 NAC 12-004.04. A Tracking Form must be completed and faxed to the HHSS PASP contractor for clients with a PASP determination.

12-014.08I Standards for Provider Participation: ISS providers may be any nursing facility certified to participate in Medicaid and Medicare. If the ISS provider subcontracts with service providers, they must be Medicaid enrolled providers. All providers of ISS must be approved and meet all applicable requirements under Title 471, Chapter 2-000, Provider Participation and other applicable sections of the NAC. However, for the purposes of effectiveness and efficiency in delivering these services, the Department approves ISS providers through a proposal process, and certifies all or part of a facility to provide ISS services. The Department will announce, through public notice, when it will entertain facility proposals. These announcements will detail to potential ISS providers the primary locations, number of beds, architectural standards, staffing requirements, and any other information to assist facilities with their proposals.

12-014.08J Staff Requirements: The facility must maintain a sufficient number of staff with the required training, competencies, and skills necessary to meet the client's needs. Training must be approved by the Department and specific to the delivery of ISS and related mental health services. At a minimum, the ISS facility must have a consulting psychiatrist. It must develop and implement a comprehensive care plan for each ISS client, ensure necessary monitoring and evaluation and must modify the care plan when appropriate. Staff must have the skills to care for the clients, know how to respond to emergency and crisis situations and fully understand client rights. The facility must provide care and treatment to clients in a safe and timely manner and maintain a safe and secure environment for all residents.

12-014.08J1 Staff Credentialing: The facility must ensure that:

1. Any staff person providing a service for which a license, certification, registration, or credential is required holds the license, certification, registration, or credential in accordance with applicable state laws;
2. The staff have the appropriate license, certification, registration, or credential before providing a service to clients including training specific to the delivery of ISS and related mental health services; and
3. It maintains evidence of the staff having appropriate license, certification, registration, or credential.

12-014.08J2 Initial Orientation: The facility must provide staff with orientation before the staff person having direct responsibility for care and treatment of clients receiving ISS provides services to clients. The training must include:

1. Client rights;
2. Job responsibilities relating to care and treatment programs and client interactions;
3. Emergency procedures including information regarding availability and notification;

4. Information on any physical and mental special needs of the clients of the facility;
5. Information on abuse, neglect, and misappropriation of money or property of a client and the reporting procedures;
6. De-escalation techniques;
7. Crisis intervention strategies;
8. Behavior management planning and techniques;
9. The role of medication in psychiatric treatment;
10. CPR and medical first aid; and
11. Strength-based services and the recovery model.

The facility must maintain documentation of staff initial orientation and training.

12-014.08J3 Ongoing Training: The facility must provide each staff person ongoing training in topics appropriate to the staff person's job duties, including meeting the needs, preferences, and protecting the rights of the clients in the facility.

12-014.08K Client Rights: The facility must ensure that clients rights are ensured in accordance with 42 CFR 483.10 and 175 NAC 12-006.05.

12-014.08L Utilization Review: The Department or its designee will provide utilization review for ISS. This includes assessing the appropriateness of the intensity of services and provid-ing ongoing utilization review of the client's progress in relation to the comprehensive care plan. At least annually, the Department or its designee will reassess clients receiving ISS, and will review and approve new service recommendations and continued eligibility for ISS.

12-014.08M Payment: The Department pays for ISS services as specified in 471 NAC 12-014.05.

12-015 MEDICAID PAYMENT WHEN A MEDICAID CLIENT RESIDING IN A NURSING FACILITY OR ICF/MR ELECTS THE MEDICARE OR MEDICAID HOSPICE BENEFIT

12-015.01 Standards for Participation: To participate in the Nebraska Medical Assistance Program (Medicaid), a hospice shall be a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified for participation in Medicare as a hospice.

12-015.01A Provider Enrollment: To complete the provider enrollment process for adult clients, the hospice shall meet the following conditions:

1. The hospice shall have a signed, written, non-resident-specific contract with each certified nursing facility or ICF/MR; and
2. The hospice shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," for each contracted nursing facility or ICF/MR and submit the form with the contract attached to the Nebraska Department of Health and Human Services.

12-015.02 Covered Services: Nebraska Medicaid shall pay the hospice for the client's board and room in the facility (NF or ICF/MR) when the following conditions are met:

1. The hospice and the facility shall have a written agreement under which the hospice is responsible for the professional management of the client's hospice care;
2. The client shall be eligible for Medicaid benefits;
3. The client shall have elected to receive the Medicare or Medicaid hospice benefit;
4. The client shall reside in a Medicaid-certified bed in the facility (NF or ICF/MR);
5. The client's medical needs must meet the Medicaid criteria and be approved for nursing facility (NF) or intermediate care for the mentally retarded (ICF/MR) level of care; and
6. The client is an adult.

Nebraska Medicaid shall not pay the hospice for the client’s board and room expense in the facility (NF or ICF/MR) if the client is a child.

12-015.03 Definition of Hospice: Hospice or hospice services shall meet the definition in 471 NAC 36-002.

12-015.04 Prior Authorization Process: The following steps shall be completed before Medicaid authorizes payment to the hospice -

1. The Preadmission Screening Process (PASARR) shall be completed before the client is admitted to the facility (see 471 NAC 12-004);
2. The hospice shall obtain prior authorization for nursing facility payment by paper or electronically. If obtained by paper, an MC-9NF shall be submitted with paper attachments according to #4 for a new admission to an NF who has chosen the Hospice benefit, or according to #5 for Medicaid covered residents in an NF converting to Hospice. If electronically, the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 276) shall be submitted with paper attachments according to #4 for a new admission to a NF who has chosen the Hospice benefit, or according to #5 for Medicaid covered residents in a NF converting to Hospice. (See Standard Electronic Transmissions at 471-000-50);
3. The hospice contracted nursing facility shall complete and electronically transmit Form MDS 2.0, "Minimum Data Set" to Central Office according to CMS requirements. For ICF/MR level of care (see 471 NAC 31-000);
4. The hospice shall forward the following to HHS Central Office -
   a. Form DPI-OBRA1 (Identification Screen);
   b. The completed Form MC-9NF (in its entirety);
   c. A copy of the DM-5 or History & Physical;
   d. The Hospice plan of care;
   e. A list of Hospice covered medications and pharmacy notification; and
   f. A list of Hospice covered medical appliances, supplies, and therapies and provider notification.
5. If the client is Medicaid eligible and already residing in the nursing facility, the hospice shall complete and submit to Central Office –
   a. Form MC-9NF;
   b. Hospice plan of care and certification;
   c. List of hospice covered medications and pharmacy notification; and
   d. List of hospice covered medical appliances, supplies, and therapies and provider notification.

12-015.04A Required Assessments: The hospice contracted nursing facility shall electronically submit to the Department -

1. Quarterly assessments of each client on MDS 3.0 Quarterly Review; and
2. Form MDS 3.0 annually or whenever any significant change occurs.

12-015.05 Payment to the Hospice: Medicaid's payment to the hospice shall be 95 percent of the case mix per diem rate established by the Department for the nursing facility in which the client resides, based on the MDS 3.0 for each individual.

The hospice shall make payment to the nursing facility for the client's board and room according to the contract between the facility and the hospice.

The Department shall not pay the nursing facility or ICF/MR for any client covered under 471 NAC 12-015 as long as the client elects to receive the Medicare Hospice benefit.

The provider shall not bill Medicaid or the Department for any provider service that is included in the Medicare hospice benefit, i.e., drugs, physician's services, equipment, etc., related to the terminal illness, nor for services covered under the Medicaid nursing facility or ICF/MR per diem.

12-015.05A Billing: Providers shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).