

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

November 24, 2020
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 877-399-0501; Participant code: 3213662#

The purpose of this hearing is to receive comments on the proposed amendment and the proposed adoption of the following regulations:

The following chapter is proposed for AMENDMENT:

Title 471 NAC 12 – *Nursing Facility Regulations*

The proposed changes will remove provisions regarding level of care determinations for children age 17 or younger that are proposed for inclusion in a new Chapter 43. Additional proposed changes include removing out-of-date language regarding the elements of quarterly reviews of the functional capacity of nursing facility residents and updating capitalization and punctuation.

The following chapter is proposed for ADOPTION:

Title 471 NAC 43 – *Nursing Facility Level of Care Determination for Children*

The adoption of this new chapter will more clearly describe policy regarding the nursing facility level of care determination for children, reflect current terminology as to treatments, and include more modern treatments. It will also more closely link the regulatory language to the language used in the new nursing facility level of care assessment tool; reorganize the regulatory treatment of this topic; and update definitions.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Due to the current public health crisis, the agency will enforce any Directed Health Measure Order on the size of gatherings that is in effect at the time of the hearing. In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments.

Interested persons may provide verbal comments by participating via phone conference line by calling 877-399-0501; Participant code: 3213662#.

Interested persons may provide written comments by mail, fax, or email, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at <http://www.sos.ne.gov>, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8223. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Joe Dondlinger
Chapter: 12	Date prepared: 09/25/2020
Subject: Nursing Facility Services	Telephone: 402-471-7855

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(<input checked="" type="checkbox"/>)	(<input checked="" type="checkbox"/>)	(<input checked="" type="checkbox"/>)
Increased Costs	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Decreased Costs	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Increased Revenue	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Decreased Revenue	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Indeterminable	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Joe Dondlinger
Chapter: 43	Date prepared: 09/25/2020
Subject: Level of Care Determination for Children	Telephone: 402-471-7855

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(<input checked="" type="checkbox"/>)	(<input checked="" type="checkbox"/>)	(<input checked="" type="checkbox"/>)
Increased Costs	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Decreased Costs	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Increased Revenue	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Decreased Revenue	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)
Indeterminable	(<input type="checkbox"/>)	(<input type="checkbox"/>)	(<input type="checkbox"/>)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 12 NURSING FACILITY REGULATIONS

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq. (the Medical Assistance Act).

002. DEFINITIONS. The following definitions apply:

002.01 ACUTE MEDICAL HOSPITAL. An institution which:

- (A) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
- (B) Meets the requirements for participation in Medicare as a hospital; and
- (C) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 Code of Federal Regulations (CFR) 482.30.

002.02 ADMISSION. An admission applies to an individual who:

- (A) Has never resided in the nursing facility (NF);
- (B) Has been formally discharged from one nursing facility (NF) and is being admitted to a different facility; or
- (C) Has been formally discharged, return not anticipated from a previous stay, by the admitting facility.

002.03 ADVANCE DIRECTIVE. A written instruction, such as a living will or power of attorney for health care, recognized under State law, or as recognized by the courts of the State, that relates to the provision of medical care if the individual becomes incapacitated.

002.04 ALLOWABLE COST. 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 this chapter.

002.05 ALTERNATIVE SERVICES. Living arrangements providing less care than nursing facility (NF), intermediate care facility for individuals with developmental disabilities (ICF/DD), institution for mental diseases (IMD), or inpatient psychiatric hospital, and more than independent living, such as adult family home, room and board, or assisted living.

002.06 APPROPRIATE. That which best meets the client's needs in the least restrictive setting.

002.07 ASSISTED LIVING RATES. 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.

002.08 BED HOLDING. Reimbursement made to a facility to hold a bed when a client is hospitalized and return is anticipated or on therapeutic leave.

002.09 BEHAVIORAL HEALTH REGIONS (BHR). Community mental health programs divided geographically into mental health regions to organize and facilitate the delivery of community mental health services.

002.10 BRAIN INJURY. 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 substantial changes in personality. A brain injury can be acute, meaning that the injury or insult occurred two years or less from the date of admission to the current extended brain injury rehabilitation program. A brain injury can also be chronic, meaning that the insult or injury that occurred more than two years before admission to the current extended brain injury rehabilitation program as described.

- (A) 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.
- (B) 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.

002.11 CATEGORICAL DETERMINATIONS. Advance group determinations under preadmission screening and resident review (PASRR) 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 (NF) 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 or physician report.

002.12 CENTER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (CDD). A facility where shelter, food, and care, including habilitation, advice, counseling, diagnosis, treatment, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have developmental disabilities.

002.13 CERTIFIED FACILITY. A facility which participates in the Medicaid program, whether that entity comprises all or a distinct part of a larger institution.

002.14 CIVIL MONEY PENALTY (CMP). A per day or per instance fine imposed against a nursing facility (NF) as a result of a survey deficiency(ies) identified by the Department of Public Health or Centers for Medicare and Medicaid Services (CMS).

002.15 COMMUNITY-BASED MENTAL HEALTH SERVICES (CBMHS). An array of mental health services, including residential, day rehabilitation, vocational support, and service coordination.

002.16 DEINSTITUTIONALIZATION. The release of institutionalized individuals from institutional care to care in the community.

002.17 DEPARTMENT. The Nebraska Department of Health and Human Services.

002.18 DEVELOPMENTAL DISABILITY (DD). A severe chronic disability of an individual five years of age or older that is:

- (A) Attributable to a mental or physical impairment or combination of mental and physical impairments.
- (B) Likely to continue indefinitely.
- (C) Manifested before the individual attains age 22.
- (D) Is likely to continue indefinitely; results in substantial functional limitations in three or more of the following major life activities:
 - (i) Self-care;
 - (ii) Receptive and expressive language;
 - (iii) Learning;
 - (iv) Mobility;
 - (v) Self-direction;
 - (vi) Capacity for independent living; and
 - (vii) Economic self-sufficiency.
- (E) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is lifelong or extended duration and is individually planned and coordinated , except that such term, when applied to infants and young children means individuals from birth to age five, inclusive, who have substantial developmental delay or congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

002.19 DISCHARGE PLAN. A plan developed by the interdisciplinary team at the time of admission which identifies:

- (A) The rationale for the client's current level of care;
- (B) The types of services the client would require in an alternate living environment; and
- (C) The steps to be taken for movement to a less restrictive living environment.

002.20 DIVISION. The Division of Medicaid and Long-Term Care.

002.21 DUAL DIAGNOSIS. For preadmission screening and resident review (PASRR) purposes, an individual is considered to have a dual diagnosis of serious mental illness and intellectual disability if they have a primary or secondary diagnosis in each category according to the definitions found in this chapter.

002.22 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.

002.23 HOME AND COMMUNITY-BASED WAIVER SERVICES FOR AGED PERSONS OR ADULTS OR CHILDREN WITH DISABILITIES. An array of community-based services available to individuals who are eligible for nursing facility (NF) services under Medicaid but choose to receive services at home. The purpose of the waiver services is to offer options to Medicaid clients who would otherwise require nursing facility (NF) services.

002.24 HOSPICE. Hospice or hospice services shall meet the definition in 471 [Nebraska Administrative Code \(NAC\)](#) 36.

002.25 IHS NURSING FACILITY (NF) PROVIDER. An Indian Health Services Nursing Facility (NF) or a Tribal Nursing Facility (NF) designated as an Indian Health Services (IHS) provider and funded by the Title I or III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638.

002.26 INPATIENT PSYCHIATRIC HOSPITAL. 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.

002.27 INSTITUTION FOR MENTAL DISEASES (IMD). A hospital, nursing facility (NF), or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

002.28 INTELLECTUAL DISABILITY (ID). Significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

002.29 SPECIALIZED ADD-ON SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY OR A RELATED CONDITION. 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.

002.29(A) SPECIALIZED ADD-ON SERVICES. Specialized add-on 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 add-on services program. Specialized add-on services may include services provided in an intermediate care facility for individuals with developmental disabilities (ICF/DD) 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 or rehabilitative needs. Specialized add-on service options include:

- (i) Assessment or evaluation for alternative communication devices;
- (ii) Behavior management program;
- (iii) Day program;
- (iv) Vocational evaluation;

- (v) Psychological or psychiatric evaluation; and
- (vi) Stimulation or environmental enhancements or use of assistive devices.

002.30 SPECIALIZED ADD-ON SERVICES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS. Services which result in the continuous and aggressive implementation of an individualized plan of care that:

- (A) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals, and, as appropriate, other professionals;
- (B) 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
- (C) Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving their 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 add-on services at the earliest possible time.

002.31 INTERDISCIPLINARY TEAM. A group of persons who meet to identify the needs of the client and develop an integrated comprehensive plan of care to accomplish these needs.

002.32 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). A facility that:

- (A) Meets the standards for licensure as established by the Nebraska Department of Health and Human Services, Division of Public Health (Public Health) and all related requirements for participation as prescribed in federal law and regulations governing medical assistance under Title XIX of the Social Security Act;
- (B) Is certified as a Title XIX Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) under Medicaid; and
- (C) Has a current provider agreement.

002.33 INTERMEDIATE SPECIALIZED SERVICES (ISS) FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS. 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 the client's regular participation, in accordance with his/her comprehensive care plan, in professionally developed and supervised activities, experiences, and therapies and 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.

002.34 LEGAL REPRESENTATIVE. 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.

002.35 LEVEL OF CARE (LOC) DETERMINATION. Medicaid's nursing facility (NF) screening for medical necessity.

002.36 LEVEL I SCREEN. The initial preadmission screening and resident review (PASRR) for all admissions to a Medicaid certified nursing facility (NF). A Level I screen must be completed before an individual is admitted to a nursing facility (NF) to determine whether there is an indication or diagnosis of serious mental illness, intellectual disability or a related condition, or a dual diagnosis.

002.37 LEVEL II EVALUATION. The preadmission screening and resident review (PASRR) assessment of any individual who has a diagnosis or indication of serious mental illness, intellectual disability or a related condition, or a dual diagnosis.

002.38 MAINTENANCE THERAPY. Therapy to maintain the client at current level or to prevent loss or deterioration of present abilities.

002.39 MEDICAID AGED AND DISABLED WAIVER. See 480 NAC 5.

002.40 MEDICAID-ELIGIBLE. The status of a client who has been determined to meet established standards to receive benefits of Medicaid.

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

002.42 MEDICARE DISTINCT PART FACILITY. Some facilities have a "distinct part" which participates only in the Medicaid program as a nursing facility (NF) and another "distinct part" which participates only in the Medicare program. In such cases the Medicaid distinct part is subject to the preadmission screening and resident review (PASRR) requirements and the Medicare part is not. If the beds are dually certified as both Medicaid and Medicare, preadmission screening and resident review (PASRR) screening processes are required because of the Medicaid participation. Likewise, a nursing facility (NF) participating solely in the Medicare program as a skilled nursing facility (SNF), with no Medicaid certification, is not subject to Level I or Level II screening through preadmission screening and resident review (PASRR).

002.43 MENTAL HEALTH (MH) SERVICES. For purposes of preadmission screening and resident review (PASRR), an array of services that are less intensive than intensive services. Mental health (MH) services may include medication monitoring, counseling and therapy, consultations with a psychiatrist, or mental health interventions. The nursing facility (NF) is responsible for ensuring the provision of mental health services.

002.44 MISAPPROPRIATION OF RESIDENT PROPERTY. The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

002.45 NEBRASKA CASEMIX INTERNET SYSTEM (NCIS). A Nebraska Medicaid web-nursing facility (NF) resident assessment and level of care information.

002.46 NEUROLOGICAL EXAMINATION. For purposes of preadmission screening and resident review (PASRR), a neurological examination may consist of the following components:

- (A) Mental status exam. A mental status exam usually contains the following components:
 - (i) Appearance - age, grooming, posture, motor activity, and stature, meaning height and weight;
 - (ii) General behavior - cooperative, withdrawn, apathetic, suspicious, aggressive, compliant, histrionic, anxious, relaxed, or hostile;
 - (iii) Affect and mood - appropriate, flat, labile, sad, elated, angry, or inappropriate;
 - (iv) Thought processes - logical, circumstantial, dissociated, obsessive, phobic, suicidal, flight of ideas, or ideas of reference;
 - (v) Perception - illusions, hallucinations, or delusions; and
 - (vi) Cognitive Functions - level of awareness, meaning orientation to time, place, and person, attention and concentration, memory both remote and recent, judgment, and insight;
- (B) Client's muscle strength and movements;
- (C) Pupillary reaction in terms of time and uniformity;
- (D) Coordination and balance;
- (E) Sensory abilities;
- (F) Lumbar and cisternal punctures as needed to detect blockage or central nervous system infection - such as meningitis, syphilis, or multiple sclerosis;
- (G) Myelography to diagnose a tumor, herniated disc, or other cause of nerve or spinal cord compression;
- (H) Brain scans and computed tomography scans to discover causes of difficulties thought to be of cerebral origin;
- (I) Angiography to determine cause of motor weakness, stroke, seizure or intractable headaches;
- (J) Electroencephalogram to detect brain tumors, infections, dementias and information concerning the cause and type of seizure disorder; and
- (K) Electromyography to assist in diagnosing muscular dystrophy and myasthenia gravis or polyneuropathy.

002.47 NURSING FACILITY (NF). A facility, or a distinct part of a facility, that:

- (A) Meets the standards for hospital, skilled nursing, or nursing facility (NF) licensure established by Public Health, and all related requirements for participation as prescribed in federal law and regulations governing medical assistance under Title XIX of the Social Security Act;
- (B) Is certified as a Title XIX NF under Medicaid. May also be certified as a Title XVIII skilled nursing facility (NF) under Medicare;
- (C) Provides 24-hour, seven-day week registered nurse (RN) or licensed practical nurse (LPN) services, meaning full-time registered nurse (RN) on day shift, unless Public Health has issued a staffing waiver; and
- (D) Has a current Medicaid provider agreement and a proof of certification on file with the Department.

002.48 NURSING FACILITY (NF) QUALITY ASSURANCE FUND. The fund created in Neb. Rev. Stat. § 68-1926 as the repository for provider tax payments remitted by nursing facilities and skilled nursing facilities.

002.49 PHYSICIAN'S CERTIFICATION. The physician's determination that the client requires the nursing facility level of care (NF LOC).

002.50 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR). A federal assessment process required of all applicants to and residents of Medicaid certified nursing facilities.

002.51 PRIOR AUTHORIZATION. Authorization of payment for certain nursing facility (NF) services based on determination of medical necessity.

002.52 PRIVATE PAY. An individual who does not meet the Medicaid eligibility requirements.

002.53 PROFESSIONAL SERVICES. Services provided by, or under the direct supervision of professional personnel, including physician services or nursing care by a registered nurse or licensed practical nurse.

002.54 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). A program that provides comprehensive, coordinated health care and long-term services and supports for voluntarily-enrolled individuals. Program of All-inclusive Care for the Elderly (PACE) provides another alternative along the continuum of available long-term care services and supports to enable participants to continue to live in their homes and communities.

002.55 QUALITY ASSURANCE ASSESSMENT. The assessment imposed under the Nursing Facility Quality Assurance Assessment Act in Neb. Rev. Stat. § 68-1917.

002.56 RATE DETERMINATION. Per diem rates by the Department. These rates may differ from rates actually paid for nursing facility (NF) services for levels of care 101, 102, 103 and 104, adjusted to include the nursing facility (NF) quality assessment component.

002.57 RATE PAYMENT. Per diem rates paid under provisions of this chapter. 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 adjusted to include the nursing facility (NF) quality assurance assessment component.

002.58 REHABILITATION. Provision of services to promote restoration of the client to their previous level of functioning.

002.59 REHABILITATIVE SERVICES. Services provided by or under the supervision of licensed or certified medical personnel, physical therapist, occupational therapist, respiratory therapist, speech pathologist, and audiologist.

002.60 RELATED CONDITION. An individual is considered to have a related condition when the individual has a severe, chronic disability that meets all of the following conditions:

- (A) It is attributable to:
 - (i) Cerebral palsy or epilepsy; or
 - (ii) Any other condition, other than serious mental illness, found to be closely related to intellectual disability because this condition results in impairment of general

intellectual functioning or adaptive behavior similar to that of persons with intellectual disability and requires treatment or services similar to those required for these persons.

- (B) It is manifested before the person reaches age 22;
- (C) It is likely to continue indefinitely;
- (D) It results in substantial functional limitations in three or more of the following areas of major life activity:
 - (i) Self-care;
 - (ii) Understanding and use of language;
 - (iii) Learning;
 - (iv) Mobility;
 - (v) Self-direction; and
 - (vi) Capacity for independent living.

002.61 REVISIT FEES. 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.

002.62 SIGNIFICANT CHANGE. A significant change is a decline or improvement in a resident's status that:

- (A) Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting;
- (B) Impacts more than one area of the residents health status; and
- (C) Requires interdisciplinary review or revision of the care plan.

002.63 SKILLED NURSING FACILITY (SNF), MEDICARE. A facility, or distinct part, that:

- (A) Meets the standards for hospital or skilled nursing licensure established by Public Health and all related requirements for participation as prescribed in federal law and regulations governing medical assistance under Title XIX of the Social Security Act;
- (B) Is certified as a Title XVIII skilled nursing facility (SNF) under Medicare, may also be certified as a Title XIX nursing facility (NF) under Medicaid.

002.64 SPECIALIZED ADD-ON SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY OR A RELATED CONDITION. Specialized add-on services are services which result in a continuous, aggressive individualized plan of care and recommended and monitored by the individual's interdisciplinary team (IDT). Specialized add-on services include habilitative services and are not provided by the nursing facility (NF). Habilitative services are medically necessary services intended to assist the individual in obtaining, maintaining, or improving developmental-age appropriate skills not fully acquired as a result of congenital, genetic, or early acquired health condition.

002.65 STRAIGHT-LINE METHOD. A depreciation method in which the cost or other basis 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.

002.66 SUMMARY OF FINDINGS REPORT. The summary and recommendation for services that addresses:

- (1) The individual's diagnoses, medical, physical, functional, and psychosocial strengths or needs;
- (2) The individual's need for any further evaluation;
- (3) Recommendations for treatment or specialized add-on service needs and any referrals determined to be appropriate; and
- (4) A summary of the findings.

002.66(A) SUMMARY OF FINDINGS REPORT INFORMATION. The Summary of Findings Report must be based on a compilation of supportive information provided by the facility, physician, mental health reviewer, and qualified intellectual disability professional (QIDP) through the preadmission screening and resident review process (PASRR).

002.67 SWING BED. Post-hospital skilled nursing and rehabilitation extended-care services, which must be provided by or under the direct supervision of professional or technical personnel and require skilled knowledge, judgment, observation, and assessment.

002.68 SWING BED FACILITY. A rural acute hospital which is certified to provide a skilled nursing facility level of care (NF LOC).

002.69 TERMINALLY ILL OR TERMINAL ILLNESS. The client is diagnosed with a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

002.70 30-MONTH CHOICE. A choice provided to an individual based on 30 months of continuous residence in a NF from time of admission to nursing facility (NF) care to the date of the Level II evaluation. The resident does not necessarily have to reside in the same nursing facility (NF) to meet the 30-month continuous residency requirement, but must reside in a nursing facility (NF) bed. Temporary absences from a nursing facility (NF) for inpatient hospital treatment for less than six months are not considered a break in residence.

002.71 URBAN. Douglas, Lancaster, Sarpy, and Washington Counties.

002.72 WAVERED FACILITY. Facilities for which the State Certification Agency has waived professional nurse staffing requirements are classified as waived if the total number of waived days exceeds 90 calendar days at any time during the reporting period.

002.73 WEIGHTED RESIDENT DAYS. A facility's inpatient days, as adjusted for the acuity level of the residents in that facility.

003. GENERAL PROVIDER REQUIREMENTS. To participate in Medicaid, providers of nursing facility (NF) services must comply with all applicable provider participation requirements codified in 471 NAC 2 and 3. In the event that provider participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this 471 NAC 12, the individual provider participation requirements in 471 NAC 12 will govern.

004. GENERAL SERVICE REQUIREMENTS.

004.01 MEDICAL NECESSITY. Nursing facility (NF) clients must meet the medical necessity requirements in 471 NAC 1, and each client must be determined to meet nursing facility level of care (NF LOC) as specified in this chapter.

005. GENERAL BILLING AND PAYMENT FOR NURSING FACILITY (NF) SERVICES.

005.01 GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this 471 NAC 12, the individual billing requirements in 471 NAC 12 will govern.

005.02 GENERAL PAYMENT REQUIREMENTS. Nebraska Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this 471 NAC 12, the individual payment regulations in 471 NAC 12 will govern.

005.03 GENERAL COST REPORTING REQUIREMENTS. The Department may require providers to submit certain cost reports for the calculation of reimbursement rates. Providers must submit such cost reports as requested and in the manner specified by the Department.

006. LEVEL OF CARE.

006.01 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.

006.01(A) LEVEL OF CARE DETERMINATION FOR ADULTS. 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) and one or more risk factors;
- (2) A limitation in at least three activities of daily living (ADL) and one or more medical treatments and interventions;
- (3) A limitation in at least three activities of daily living (ADL) and one or more areas of cognitive limitation; or
- (4) A limitation in at least one activities of daily living (ADL) and at least one risk factor and at least one area of cognitive limitation.

006.01(A)(i) ACTIVITIES OF DAILY LIVING (ADL).

- (1) 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, or sponge bath;
- (2) Continence: The control of one's body to empty the bladder or bowel on time. The ability to change incontinence pads or briefs, cleansing, or disposing of

soiled articles. Ability to manage ostomy equipment, and ability to self-catheterize;

- (3) Dressing or 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;
- (4) Eating: The ability to take nourishment. This does not include meal preparation;
- (5) Mobility: The ability to move from place to place indoors or outside;
- (6) 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; and
- (7) 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.

006.01(A)(ii) RISK FACTORS.

- (1) 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;
- (2) 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; and
- (3) 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 or informal support system, or freedom from abuse or neglect.

006.01(A)(iii) MEDICAL TREATMENTS.

- (1) 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 or evaluate the need to contact skilled medical professionals;
- (2) Due to the complexity created by multiple, interrelated medical conditions, the potential for the individual's medical instability is high or exists; and
- (3) The individual requires at least one ongoing medical or nursing service.

006.01(A)(iv) COGNITIVE FUNCTION.

- (1) Memory: Ability to remember past and present events; does not need cueing;
- (2) Orientation: Fully oriented to person, place, and time;
- (3) Communication: Ability to communicate information in an intelligible manner, and the ability to understand information conveyed; and
- (4) Judgment: Ability to solve problems well and make appropriate decisions.

006.01(B) LEVEL OF CARE (LOC) DETERMINATION FOR CHILDREN AGE 17 OR YOUNGER. See 471 NAC 43. ~~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 this chapter; and~~
- ~~(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 or treatment need;~~
 - ~~(b) Limitations in at least six activities of daily living (ADL); or~~
 - ~~(c) Limitations in at least four activities of daily living (ADL) and at the presence of least three other considerations.~~~~

~~006.01(B)(i) AGE. 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.~~

~~006.01(B)(ii) LEVEL OF CARE (LOC) 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 or legal representative or 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.~~

~~006.01(B)(ii)(1) DETERMINATION OF MEDICAL CONDITIONS AND MEDICAL TREATMENTS. To qualify with a limitation in this category, a child must have a defined, documented medical condition or receipt of treatment, which satisfies the requirements of this chapter.~~

~~006.01(B)(ii)(1)(a) DEFINED MEDICAL TREATMENT AND MEDICAL CONDITIONS. The following medical conditions and treatments are considered in determining nursing facility level of care (NF LOC) eligibility:~~

~~(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 intravenous (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 percent 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 intravenous (IV) coagulation factor medication, packed red blood cells and platelets, or enzyme infusion;~~
- ~~(10) Antineoplastic therapy which includes oral or intravenous (IV) chemotherapy or radiation; and~~
- ~~(11) Chronic pain management program with daily routine narcotic analgesics;~~
- ~~(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~~~~
- ~~(iii) A condition which a licensed medical provider has documented as terminal or a persistent condition in which the absence of active treatment would result in hospitalization.~~

~~006.01(B)(ii)(1)(b) ADDITIONAL CRITERIA FOR MEDICAL CONDITIONS AND TREATMENTS. In addition to having a medical condition or treatment identified in above the present medical condition or treatment must:~~

- ~~(i) Impact the child's functioning or independence on a daily basis; and~~
- ~~(ii) Require physical assistance of another person:
 - ~~(1) To prevent a decline in health status; or~~
 - ~~(2) When the child is physically or cognitively unable to self-perform the medically necessary treatments.~~~~

~~006.01(B)(ii)(1)(b)(a) 36 MONTHS THROUGH 17 YEARS. 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 or independence is required.~~

~~006.01(C) ACTIVITIES OF DAILY LIVING (ADL) FOR CHILDREN AGE 36 MONTHS THROUGH 17 YEARS. Information about limitations in activities of daily living (ADL) is obtained from observation of the child in the home setting, reports from parents, guardians or caregivers, current medical records, and school records. Activities in daily living (ADL) are considered a limitation when the child, due to their physical disabilities, requires physical assistance from another person on a daily basis, or constant supervision due to documented weakness or problems with balance to complete the tasks associated with each activity of daily living (ADL) defined in this section. For the purposes of this section, the term "ability" must 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. 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 or 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 or 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. 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 and 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. This also includes the ability to be self-sufficient in a wheelchair, if a wheelchair is the primary mode of mobility;~~
- ~~(5) Personal Hygiene: The ability to complete at least two of the following tasks: comb or 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 and 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 or 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 or chairs, and in and out of a vehicle.~~

~~006.01(C)(i) 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.~~

006.02 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 evaluation; 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.

006.02(A) SPECIAL CIRCUMSTANCES NOT EVALUATED OR SCREENED. Level of care (LOC) will not be evaluated or reevaluated for Medicaid clients who:

- (i) 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;
- (ii) Are Medicaid-eligible clients who admit to the nursing facility (NF) under hospice care;

- (iii) Are nursing facility (NF) residents who elect hospice upon becoming Medicaid eligible;
- (iv) 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;
- (v) Direct transfer from one nursing facility (NF) to another nursing facility (NF);
- (vi) Have a preadmission screening and resident review (PASRR) Level II level of care (LOC) determination indicating the resident meets nursing facility level of care (NF LOC);
- (vii) Are currently, or were previously eligible the month prior to nursing facility (NF) admission, for the Aged and Disabled Waiver program through the Department;
- (viii) Are admitted to a special needs nursing facility (NF) unit;
- (ix) Are currently eligible for the Program of All-Inclusive Care for the Elderly (PACE) through the Department; or
- (x) Are seeking out-of-state nursing facility (NF) admission.

006.02(B) 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, the amount of assistance required and the complexity of the care.

006.02(C) REFERRAL.

006.02(C)(i) 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.

006.02(C)(ii) RECEIVING REFERRALS. When the Department or its agent 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).

006.02(C)(iii) 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 must complete a level of care (LOC) evaluation within 48 hours. If the evaluation is not completed, the applicant for admission must be deemed to be appropriate for admission until a level of care (LOC) determination is completed and any required notice is given.

006.02(C)(iii)(1) 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 must perform an evaluation. If the following conditions are met, Medicaid coverage will be retroactive to the date of Medicaid eligibility:

- (a) 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;
- (b) 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) must provide information on the date and means by which information about Medicaid eligibility was obtained; and
- (c) The resident meets the nursing facility level of care (NF LOC) criteria.

006.02(C)(iii)(2) 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.

006.02(C)(iii)(3) REFERRAL AFTER DEATH OR DISCHARGE. A level of care (LOC) referral will also be accepted and a medical records-based level of care (LOC) determination 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.

006.02(C)(iii)(4) 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 of care (LOC) determination may be used to substantiate nursing facility level of care (NF LOC) in the following cases:

- (a) A Program of All-inclusive Care for the Elderly (PACE) recipient immediately admits to, or already resides in, a nursing facility (NF) following their disenrollment from the Program of All-inclusive Care for the Elderly (PACE); or
- (b) A Program of All-inclusive Care for the Elderly (PACE) recipient admits to a nursing facility (NF) the month after disenrollment from the Program of All-inclusive Care for the Elderly (PACE).

006.02(C)(iii)(5) DETERMINATION OTHERWISE REQUIRED. A level of care (LOC) determination will be required in all other cases for nursing facility (NF) admission.

006.02(D) OUTCOMES OF THE EVALUATION.

006.02(D)(i) 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.

006.02(D)(ii) 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. 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.

006.02(D)(iii) 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).

006.02(E) NOTICES AND APPEALS.

006.02(E)(i) LEVEL OF CARE (LOC) DETERMINATION NOTIFICATION. Medicaid staff send notification to each client, family, or 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.

006.02(E)(ii) 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. 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 must refer the person to appropriate services.

007. PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR). When an individual requests admission to or continuous residence in a Medicaid-certified nursing facility (NF), the facility must implement the preadmission screening and resident review (PASRR) as defined in this chapter. An individual who has an indication or diagnosis of serious mental illness, intellectual disability or a related condition, or a dual diagnosis may be admitted to a nursing facility (NF) or continue to reside in a nursing facility (NF) only when the individual is determined to be appropriate for nursing facility (NF) services through the preadmission screening and resident review (PASRR). The preadmission screening and resident review (PASRR) provides the following to an individual with a diagnosis or indication of serious mental illness, intellectual disability or a related condition, or a dual diagnosis:

- (A) A determination whether the individual has serious mental illness, intellectual disability or a related condition, or a dual diagnosis;
- (B) A determination whether the level of services provided by a nursing facility (NF) is appropriate to meet the individual's needs; and
- (C) A recommendation for services that addresses the individual's needs in a nursing facility (NF) or in an alternative placement.

007.01 PURPOSE OF THE PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR). The purpose of the preadmission screening and resident review (PASRR) is to:

- (A) Determine the appropriateness of nursing facility (NF) care for persons with serious mental illness, intellectual disability or a related condition, or a dual diagnosis;
- (B) Prevent the placement of individuals with serious mental illness, intellectual disability or a related condition, or a dual diagnosis in nursing facilities unless their medical needs clearly indicate that they require the level of care (LOC) provided by a nursing facility (NF);
- (C) Coordinate services needs among the health care industry and the mental health and developmental disability systems;
- (D) Comply with state and federal requirements mandating an evaluation process that facilitates the nursing facility's (NF) responsibility to provide services and activities to attain and maintain the highest practical physical, mental, and psychosocial well-being of each resident; and
- (E) Assist with the placement of persons found inappropriate for nursing facility (NF) care into more appropriate, least restrictive services.

007.02 LEVEL I SCREEN. A preadmission screening and resident review (PASRR) is required to be submitted to the Department for:

- (1) All persons who have requested admission to a Medicaid certified nursing facility (NF);
- (2) Any request for a first time admission or readmission to a Medicaid certified nursing facility (NF) for a resident who has been treated in an inpatient psychiatric setting or equally intensive service, including the crisis unit, and when the Department contractor has determined that the individual qualifies for such preadmission review per criteria provided in this chapter;
- (3) Was previously formally discharged from a nursing facility (NF) and is applying for admission to the same or another Medicaid certified nursing facility (NF);
- (4) Was evaluated through the preadmission screening and resident review (PASRR) Level II process more than 90 days before admission to a Medicaid certified nursing facility (NF);
- (5) Was screened as a negative Level I but whose placement was delayed longer than 60 days from the previous Level I screen; and
- (6) When a status change event occurs as specified below.

007.02(A) STATUS CHANGE. For the purpose of this chapter, the term "status change" references the obligation to complete a new Level I preadmission screening and resident review (PASRR) evaluation. The status change process is required for all nursing facility (NF) residents who:

- (i) Have previously been screened with a negative outcome through the preadmission screening and resident review (PASRR) process but have been

- determined to exhibit signs, symptoms, or behaviors suggesting the presence of a diagnosis of serious mental illness or intellectual disability or related conditions;
- (ii) Have demonstrated an increase in symptoms or behaviors to the extent that there is a change in mental health or intellectual disability treatment needs;
 - (iii) Have demonstrated a significant physical status improvement such that they are more likely to respond to special treatment for that condition or may be considered appropriate for a less restrictive placement alternative;
 - (iv) Have required inpatient psychiatric treatment. A Level II status change is required prior to the individual's readmission to the facility;
 - (v) Have been approved for nursing facility (NF) stay for a short term period and the individual's stay is expected to exceed the approved time frame; or
 - (vi) Current condition or treatment is significantly different than described in the resident's current Level I or Level II determination.

007.03 LEVEL I IDENTIFICATION SCREEN OUTCOMES. The Nebraska Level I Preadmission Screening and Resident Review (PASRR) form must be submitted to the Department prior to an individual's admission to a Medicaid certified nursing facility (NF) and under those circumstances specified above. Outcomes are as follows:

- (A) Negative screens - Negative Level I screen means the results of a Level I screen that indicates the individual does not require a Level II evaluation;
- (B) Positive Level I screen means results of a Level I screen which indicate that an individual falls within federal requirements for a mandatory Level II evaluation;
- (C) Questionable screens - In cases where information suggests the possibility of a serious mental illness or intellectual disability or related condition, the referral source must submit medical records information with the Nebraska Level I Preadmission Screening and Resident Review (PASRR) form, as applicable, to clarify the presence or absence of the suspected disorder. When an individual's condition suggests that some but not all criteria are met to qualify as mental illness or intellectual disability or related condition under the criteria provided in this chapter, the Department will exclude the individual from the preadmission screening and resident review (PASRR) 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 Department for consideration of Level II need;
- (D) Exempted hospital discharges and categorical determination - 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 (NF) without requiring performance of an on-site Level II evaluation. The options are indicated on the Nebraska Categorical Determinations and Exemptions form which offer either short term or categorical approvals, based upon certain presenting circumstances. Short term options allow for only brief admission, whereby further contact must be made with the Department 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; and
- (E) Positive Level I Screen - The reviewing agent will request medical records information which sufficiently supports that the individual meets criteria for a preadmission screening and resident review (PASRR) evaluation as indicated in this chapter. If the individual is identified as potentially having an intellectual disability or related condition, the Level I review agency will additionally request information regarding

whether the presence of intellectual disability has been clinically diagnosed through psychological testing.

007.04 TRANSFERS. A nursing facility (NF) to nursing facility (NF) transfer does not require the completion of a new Nebraska Level I Preadmission Screening and Resident Review (PASRR) form or the completion of a new Level II preadmission screening and resident review (PASRR) evaluation if the transferring facility has completed the appropriate preadmission screening and resident review (PASRR) screening. The discharging facility must send a copy of the most recent Level I or II, as applicable, screening information to the admitting facility at the time of transfer. The Level II determination applies to nursing facility (NF) services and is not facility-specific. The only exception is for a nursing facility (NF) that is providing specialized services approved through a current Level II determination. If the client transfers to another nursing facility (NF) and the same specialized service cannot be provided, these determinations may not be transferred from one facility to another.

007.05 IDENTIFICATION CRITERIA.

007.05(A) IDENTIFICATION CRITERIA FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS. An individual is considered to have a serious mental illness (SMI) and requires a Level II preadmission screening and resident review (PASRR) evaluation if the individual meets all three of the following three indicators:

- (1) Diagnosis indicator: The individual has a psychiatric diagnosis which, by accepted clinical standards, is determined to be a serious and persistent psychiatric condition, diagnosable under the current edition of the Diagnostic and Statistical Manual of Mental Disorders. 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 serious 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 indicator;
- (2) Impairment and behavior indicators: 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 they 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 of recent treatment: The treatment history indicates that the individual has experienced at least one of the following:
- (a) Psychiatric treatment more intensive than outpatient care once within the past two years for a nursing facility (NF) resident or more than once in the past two years for a nursing facility (NF) applicant;
 - (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 episodes of significant disruption may include an involuntary psychiatric hospitalization, suicidal attempts or gestures, 1:1 monitoring, or other issues which are safety-related or involved; or
 - (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.

007.05(A)(i) INDICATORS. In addition to the criteria listed in above, the following indicators may be considered evidence of a serious mental illness:

- (1) The individual has a history 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.

007.05(A)(ii) DEMENTIA, ALZHEIMER'S DISEASE, OR RELATED DISORDER. An individual is considered not to require a preadmission screening and resident review (PASRR) 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 current edition of the Diagnostic and Statistical Manual. 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 to provide documentation to the Department that the dementing condition is primary. 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. For purposes of preadmission screening and resident review (PASRR), the neurological examination may be completed by a medical doctor. The physician's findings must be clearly substantiated and must focus on a physical examination and a psychological examination including mental status and 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.

007.05(B) IDENTIFICATION CRITERIA FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY OR A RELATED CONDITION. An individual is considered to have an intellectual Disability or a related condition and requires a Level II evaluation if the individual meets any of the following criteria:

- (1) Suspicion or diagnosis of intellectual disability (ID): An individual is considered to have intellectual disability if he or she has a level of intellectual disability as described in the American Association on Mental Deficiency's Manual or Classification in Mental Deficiency (1983). Intellectual Disability refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period; or
- (2) Suspicion or presence of a Related Condition or Developmental Disability: 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 mental illness (MI), found to be closely related to intellectual disability (ID) because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with intellectual disability (ID) and requires treatment or services similar to those required for such persons;
 - (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:
 - (i) Self-care;
 - (ii) Understanding and use of language;
 - (iii) Learning;
 - (iv) Mobility;
 - (v) Self-direction; or
 - (vi) Capacity for independent living.

007.05(B)(i) NO KNOWN DIAGNOSIS. In the absence of a known diagnosis of intellectual disability or a related condition, a suspicion or history of treatment by an agency serving individuals with such conditions should trigger the housing or receiving facility to contact the Department for a determination of need for Level II evaluation under the preadmission screening and resident review (PASRR) program.

007.06 NEGATIVE SCREENS. If a client does not require a Level II evaluation and is admitted to the nursing facility (NF), the facility must retain a copy of the Nebraska Level I Preadmission Screening and Resident Review (PASRR) form in the resident's permanent nursing facility (NF) record.

007.06(A) MEDICAID PAYMENT. If a Medicaid-eligible client does not require a Level II evaluation and is admitted to the nursing facility (NF), Medicaid payment for nursing facility (NF) services can begin no earlier than the date of the Level I preadmission screening and resident review (PASRR) screen is completed.

007.07 CATEGORICAL DETERMINATIONS AND EXEMPTIONS. If the results of a Level I screen, based on current medical documentation, indicate that an individual has a diagnosis or an indication of serious mental illness, intellectual disability 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 nursing facility (NF) admission. Admission to the nursing facility (NF) for an individual qualifying under a categorical determination or extended hospital stay may proceed only after approval is provided by Department. 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 Department. The Nebraska Level I Preadmission Screening and Resident Review (PASRR) form and Categorical Determination and Exemptions form must be submitted along with the above. If it is determined that the individual's stay in the nursing facility (NF) will continue beyond the approved seven-day time frame, the receiving facility must contact the Department 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 the Nebraska Level I Preadmission Screening and Resident Review (PASRR) form and Categorical Determination and Exemptions form to the Department. If it is determined that the individual's stay in the nursing facility (NF) will continue beyond the approved 30-day time frame, the receiving facility must contact the Department 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 intellectual disability or related condition: The individual has intellectual disability 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 the Department or contractor along with Nebraska Level I Preadmission Screening and Resident Review (PASRR) form and Categorical Determination and Exemptions form;
- (4) Categorical serious medical - The individual's medical condition renders him or her unable to benefit from a plan of specialized services and clearly meets criteria for nursing facility (NF) care. Applicable conditions include: coma, ventilator dependence, brain stem injury, or 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 Nebraska Level I Preadmission Screening and Resident Review (PASRR) form and the Categorical Determination and Exemptions form to the Department before the individual's admission can occur; or
- (5) Exempted hospital discharge - Federal regulations also offer an exemption from the Level II preadmission screening and resident review (PASRR) process for individuals with serious mental illness or intellectual disability or related conditions who are being discharged from the hospital to the nursing facility (NF) for a nursing facility (NF) stay

- which is expected to not exceed 30 calendar days. The hospital must complete the Categorical Determinations and Exemptions form with a physician's certification to indicate necessity. Qualifying criteria for the exempted hospital discharge exemption are as follows:
- (a) The individual meets criteria for serious mental illness or intellectual disability or a related condition as described in this chapter;
 - (b) The individual is being admitted to a nursing facility (NF) directly from a hospital after receiving acute inpatient medical care at the hospital, excluding inpatient psychiatric care;
 - (c) The individual requires nursing facility (NF) services for the condition for which they received care; and
 - (d) The individual's attending physician has certified on the hospital discharge orders or the nursing facility (NF) admission orders that admission to the nursing facility (NF) is likely to require less than 30 days of nursing facility (NF) services.
- (6) 60 day convalescent option: The 60 day convalescent option is an allowable categorical exemption for an individual with a serious mental illness or intellectual disability or related condition. To qualify, the individual must require nursing facility level of care (NF LOC) following hospitalization from an acute physical illness and does not meet all of the criteria for an exempted hospital discharge exemption as defined above.

007.07(A) DOCUMENTATION OF CATEGORICAL DETERMINATIONS AND EXEMPTED HOSPITAL DISCHARGE. The facility must submit the Nebraska Level I Preadmission Screening and Resident Review (PASRR) form and Categorical Determination and Exemptions form with documentation supporting the request to the Department before admission for an individual with serious mental illness, intellectual disability, or a related condition may occur.

007.07(B) STAY BEYOND SPECIFIED LIMITS. If the individual with serious mental illness, intellectual disability, or a related condition qualified for a categorical determination or an exempted hospital discharge which involved a time limited admission, the Department 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 subsequent Level II evaluation. The facility must coordinate such a contact through submission of an updated Level I preadmission screening and resident review (PASRR) to the Department. The on-site Level II evaluation will be completed by the fifth business day from the Level II referral date. Medicaid payment is not allowed beyond the specified time limits if a Level I status change is not completed and sent to the Department prior to the conclusion of the time frame.

007.07(C) MEDICAID PAYMENT. If the documentation supports the categorical determination or exemption, Medicaid payment can begin no earlier than the date the Nebraska Level I Preadmission Screening and Resident Review (PASRR) is completed. If the documentation does not support the categorical determination, a Level II evaluation must be initiated immediately. Medicaid payment can begin no earlier than the date of the Level II determination.

007.08 INDIVIDUALS WHO REQUIRE A LEVEL II EVALUATION. Following the first time identification when an individual requires a Level II evaluation, the Department will notify the individual or their legal representative that they have an indication or diagnosis of serious mental illness or intellectual disability or related condition and are being referred for a Level II evaluation. The nursing facility (NF), hospital, or other party must submit the signed release of information to the Department prior to conducting the Level II evaluation. If the Department determines that additional information is required to determine whether the individual has a condition warranting a Level II preadmission screening and resident review (PASRR) evaluation, the referring source must submit requested information to the Department by the request deadline. Failure to provide requested information by the request deadline may result in a cancelled preadmission screening and resident review (PASRR) determination review. Subsequently, a new Level I preadmission screening and resident review will be required to be submitted for review. The nursing facility (NF) retains a copy of the Preadmission Screening and Resident Review (PASRR) Level I form and the Release of Information form in the resident's permanent file.

007.08(A) MEDICAID PAYMENT. If a Medicaid-eligible client requires a Level II evaluation and is admitted to the nursing facility (NF), Medicaid payment for nursing facility (NF) services can begin no earlier than the date of the preadmission screening and resident review (PASRR) final determination. If the initial Level II determination approval was time limited, continued payment will be allowed provided that a status change preadmission screening and resident review (PASRR) is submitted to the Department or its agent and the individual is determined to meet nursing facility (NF) preadmission screening and resident review (PASRR) placement criteria no later than the expiration date of the initial Level II evaluation.

007.08(B) ADMISSION TO A NEBRASKA FACILITY FROM ANOTHER STATE. The nursing facility (NF) must notify the Department of potential admissions and must complete the Nebraska Level I Preadmission Screening and Resident Review (PASRR) form and, as applicable, the Categorical Determinations and Exemptions form prior to the individual's admission to a Nebraska Medicaid-certified nursing facility (NF). If the individual is determined by the Department 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 the Department is unable to arrange an on-site evaluation in the transferring individual's home state, the Department must request medical records information to make document-based determination of need for nursing facility (NF) and need for specialized services, if indicated. If unable to make a determination of nursing facility (NF) need based upon Medicaid nursing facility level of care (NF LOC) criteria, Medicaid coverage for nursing facility (NF) services for the individual will be denied.

007.08(C) 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 (NF), the preadmission process including the Level II evaluation, if required, must be completed before the individual leaves the state.

007.09 LEVEL II EVALUATION. The Level II evaluation process determines:

- (1) Whether the individual has serious mental illness or intellectual disability or related condition as defined by federal regulations and as defined within this chapter;

- (2) Whether the level of services provided by a nursing facility (NF) or another institutional placement is appropriate to meet the individual's needs; and
- (3) For applicants determined to require nursing facility (NF) placement and for all evaluated nursing facility (NF) residents, services which are required to meet the evaluated individual's needs, are the responsibility of the receiving or retaining facility or specialized services, which are the responsibility of the State.

007.09(A) RETURNING FROM RECEIVING INTENSIVE TREATMENT SERVICES FOR SERIOUS MENTAL ILLNESS. If an individual is returning to a nursing facility (NF) from receiving intensive treatment services for serious mental illness, a new Level I screen is required to determine further screening requirements. If the Level I screen indicates that the individual meets serious mental illness criteria as indicated in this chapter, 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.

007.09(B) FACILITY ACTION. For each individual who requires a Level II evaluation, the nursing facility (NF), hospital, or other party must obtain medical records information. The referring source must submit the information to the Department so that a determination of Level II need can be made.

007.09(C) MENTAL HEALTH EVALUATOR ACTION. For each individual with an indication or diagnosis of serious mental illness, the evaluator must complete a comprehensive review, which contains medical, functional, and psychosocial information. The on-site evaluation and the final validation and Summary of Findings Report must be completed by the third 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 serious mental illness, summarize the medical and social history, provide recommendations to meet the service needs, and provide recommendations regarding placement needs. The final Level II determination must be completed by the fifth business day from the date of the Level II referral.

007.09(D) INTELLECTUAL DISABILITY OR RELATED CONDITION EVALUATOR ACTION. For each individual with an indication of intellectual disability or a related condition, the evaluator will complete the on-site evaluation. The on-site evaluation and the final determination and Summary of Findings Report will be completed by the fifth business day of the referral. Intellectual testing will be administered to establish a diagnosis if:

- (1) Lack of social-historical information from a third party knowledgeable of the individual;
- (2) The individual is not currently or has not received services from a community-based developmental disability (DD) provider;

- (3) The individual is not currently or was not placed in an intermediate care facility for individuals with developmental disabilities (ICF/DD); or
- (4) No indication of previous intelligence quotient (IQ) testing is available.

007.09(D)(i) INTELLIGENCE QUOTIENT (IQ) TESTING. Intelligence quotient (IQ) testing will only be performed as a last resort to substantiate an intellectual disability or related condition diagnosis.

007.09(D)(ii) ADAPTIVE BEHAVIOR. Adaptive behavior will always be assessed.

007.09(D)(iii) PSYCHOLOGICAL EVALUATION REPORT. The psychological evaluation report must include the following information:

- (1) Type of tests administered to determine intelligence quotient (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.

007.09(D)(iv) PSYCHOLOGICAL EVALUATION PROFESSIONALS. The psychological evaluation must be completed by licensed or certified professionals who meet one of the following criteria:

- (a) A licensed psychologist;
- (b) A licensed and certified clinical psychologist;
- (c) A certified psychologist (Master of Science) in a clinical setting - a psychological evaluation completed by certified psychologist must be counter-signed by a licensed and certified clinical psychologist;
- (d) A certified counselor (Master of Arts) - a certified counselor can only complete psychological evaluations as specified by the Department of Health and Human Services Division of Public Health's Bureau of Examining Board.

007.09(D)(iv)(1) LICENSE AND CERTIFICATION. All licensure and certifications must be current and approved according to the Department of Health and Human Services Division of Public Health requirements.

007.09(D)(iv)(2) QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL. Medical, functionality and psychosocial information will be obtained by a qualified intellectual disability professional (QIDP). This protocol identifies the extent to which the individual's status compares with each of the following skill deficits typically associated with individuals with intellectual disability or related conditions:

- (a) Ability to accomplish most self-care needs;
- (b) Ability to comprehend simple commands;
- (c) Ability to communicate most needs and wants;
- (d) Ability to perform a task without systematic long term supervision or support;

- (e) Ability to learn new skills without intensive, consistent training;
- (f) Ability to apply skills learned in a training situation to other settings without intensive, consistent training;
- (g) Ability to demonstrate behavior appropriate to the time, situation, or place without direct supervision;
- (h) Demonstration of severe maladaptive behaviors which place the individual or others in jeopardy to health and safety;
- (i) Ability or extreme difficulty in making decisions requiring informed consent;
- (j) Other skill deficits or specialized training needs which necessitate the availability of trained intellectual disability (ID) personnel, 24 hours per day, to teach the individual functional skills; and
- (k) Ability to commute independently.

007.09(E) PARTICIPATION IN THE LEVEL II EVALUATION. The mental health or qualified intellectual disability professional (QIDP) evaluator must contact the retaining facility to coordinate the time and date of the on-site evaluation and to assure that the release of information form has been completed and signed as required. If the individual has a legal representative, the facility must notify the legal representative of the scheduled assessment time and date and invite him or her to participate. The family also must receive notification from the facility of the pending evaluation and be allowed to participate, if available, with consent from the individual or their legal representative.

007.09(F) PRE-EXISTING DATA. Relevant evaluative data collected prior to the Level II evaluation may be used if the data is considered accurate and reflects the current functional status of the individual. To supplement existing data, the mental health reviewer or qualified intellectual disability professional (QIDP) must gather additional information necessary to assess proper placement and treatment.

007.10 HALTING THE LEVEL II EVALUATION. If, at any time during the Level II evaluation, it is found that the individual does not meet criteria for serious mental illness or intellectual disability or a related condition, the Level II evaluation must be halted and admission to the nursing facility (NF) can proceed according to standard procedures for admission. A halted Level II preadmission screening and resident review (PASRR) evaluation means that a nursing facility level of care (NF LOC) was not determined. If the individual's status changes, later suggesting the presence of serious mental illness or intellectual disability or a related condition, the Level I must be resubmitted to the Department as a status change.

007.11 FINAL DETERMINATION CRITERIA. The Department or contractor must use the following criteria to make the final determination for each individual who requires a Level II evaluation.

007.11(A) APPROPRIATE FOR NURSING FACILITY (NF) SERVICES. An individual with serious mental illness, intellectual disability or a related condition, is considered appropriate for Nursing Facility services if it is determined through a Level II evaluation that:

- (i) Nursing needs are primary and may include treatment and monitoring of the individual's medical needs, a protective structured environment, assistance with

- activities of daily living (ADL), nursing supervision, and monitoring to avoid further deterioration or complications;
- (ii) 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;
 - (iii) 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
 - (iv) Intellectual disability or related condition needs do not require intensive treatment services but may require intellectual disability or related condition services as part of the overall plan of care, to include but not limited to services such as physical therapy, occupational therapy, speech, and social or recreational activities.

007.11(B) INAPPROPRIATE FOR NURSING FACILITY (NF) SERVICES. An individual with serious mental illness, intellectual disability or a related condition, is considered inappropriate for nursing facility (NF) services if it is determined through a Level II evaluation that they do not require nursing facility (NF) services but do require:

- (i) Inpatient psychiatric treatment or equally intensive services;
- (ii) Mental health, intellectual disability or developmentally disabled services at a level which is defined in this chapter as intensive treatment services; or
- (iii) Alternative services.

007.12 NOTIFICATION OF FINAL DETERMINATION. The Department or its agent must make a final determination after reviewing the information obtained from the Level II evaluation and provide a Summary of Findings report indicating the results of the Level II evaluation. The nursing facility (NF) must incorporate all recommendations included in the Summary of Findings into the resident's plan of care and update facility records with current diagnosis and other information resulting from the evaluation.

007.13 CHOICE. Individuals who have resided in a nursing facility (NF) for 30 continuous months may elect continued nursing facility (NF) residence if the preadmission screening and resident review (PASRR) evaluation determines that nursing facility (NF) care is inappropriate but specialized services, which can be provided by the State in the nursing facility (NF), as needed. The 30 months of continuous residence is calculated back from the first preadmission screening and resident review (PASRR) determination which found that the individual was not in need of nursing facility (NF) care. The initial choice provision and alternative placement options must be explained as appropriate. If the individual chooses to remain in the nursing facility (NF) under the choice provision, the nursing facility (NF) 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 community-based developmental disability service provider (CBDDSP) or the behavioral health regions (BHR) by the Department or its agent for an on-site discussion. The choice stays with the individual until their status changes, including a change in determination from inappropriate for nursing facility (NF) care to appropriate for nursing facility (NF) care, a

denial of specialized services, or if the individual leaves the nursing facility (NF). When a new admission occurs, a new Level II determination will be made.

008. NURSING FACILITY (NF) SERVICES.

008.01 STANDARDS FOR PARTICIPATION FOR NURSING FACILITIES. The nursing facility (NF) must meet:

- (A) The Nebraska nursing home licensure, and Medicare and 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;
- (B) The facility type, program and operational definitions; and
- (C) The definition of a nursing facility (NF) as defined in this chapter, and in section 1919 of the Social Security Act.

008.02 PROVIDER AGREEMENT. To participate as a provider the nursing facility (NF) must meet the standards in this chapter and must complete the appropriate provider agreement. The facility submits the completed and signed form to Medicaid for approval and enrollment as a provider.

008.03 MINIMUM DATA SET RESIDENT ASSESSMENT. The nursing facility (NF) must conduct an interdisciplinary assessment of every resident's functional capacity, regardless of payor source. This assessment must utilize the minimum data set (MDS). The facility must submit one copy of each assessment to the Department within 30 days of completion.

008.03(A) REGISTERED NURSE (RN) ASSESSMENT COORDINATOR. Each facility must designate a registered nurse (RN) assessment coordinator. The facility must inform the Department of the name of the assessment coordinator and must promptly inform the Department of any changes. The assessment coordinator must coordinate each assessment with the appropriate participation of health professionals. Each individual who completes a portion of an assessment must sign and certify as to the accuracy of that portion of the assessment. The assessment coordinator must sign and certify the completion of the assessment.

008.03(B) FREQUENCY OF ASSESSMENTS. An assessment must be completed:

- (i) Initial admission: Must be completed by 14th day of resident's stay;
- (ii) Annual reassessment: Must be completed within 12 months of most recent full assessment;
- (iii) Significant change in status reassessment: Must be completed by the end of the 14th calendar day following determination that a significant change has occurred; and
- (iv) Quarterly assessment: Must be completed no less frequently than once every three months.

008.03(C) OTHER CHANGES. The facility need not assess the resident if declines in a resident's physical, mental, or psychosocial well-being are attributable to:

- (i) Discrete and easily reversible causes documented in the resident's record and for which facility staff can initiate corrective action;

- (ii) 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
- (iii) Well established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions.

~~008.03(D) QUARTERLY REVIEW. The nursing facility must review the following elements for all residents quarterly, document the results, and revise the plan of care, if indicated. The facility must submit one copy of each quarterly assessment to the Department within 30 days of completion. The elements which must be reviewed and submitted are:~~

- ~~(i) Resident name;~~
- ~~(ii) Room number;~~
- ~~(iii) Date of reentry;~~
- ~~(iv) Medical record number;~~
- ~~(v) Comatose;~~
- ~~(vi) Memory;~~
- ~~(vii) Cognitive skills for daily decision-making;~~
- ~~(viii) Indicators of delirium - Periodic disordered thinking or awareness;~~
- ~~(ix) Making self understood;~~
- ~~(x) Ability to understand others;~~
- ~~(xi) Indicators of depression, anxiety, sad mood;~~
- ~~(xii) Mood persistence;~~
- ~~(xiii) Behavioral symptoms;~~
- ~~(xiv) Activities of daily living self-performance;~~
- ~~(xv) Bathing;~~
- ~~(xvi) Functional limitation in range of motion;~~
- ~~(xvii) Modes of transfer;~~
- ~~(xviii) Continence in last 14 days;~~
- ~~(xix) Bowel Elimination pattern;~~
- ~~(xx) Disease diagnoses;~~
- ~~(xxi) Infections;~~
- ~~(xxii) Other current diagnosis;~~
- ~~(xxiii) Problem conditions;~~
- ~~(xxiv) Pain symptoms;~~
- ~~(xxv) Accidents;~~
- ~~(xxvi) Stability of conditions;~~
- ~~(xxvii) Oral and nutritional status;~~
- ~~(xxviii) Weight change;~~
- ~~(xxix) Nutritional approaches;~~
- ~~(xxx) Skin condition;~~
- ~~(xxxi) Ulcers;~~
- ~~(xxxii) Time awake;~~
- ~~(xxxiii) Average time involved in activities;~~
- ~~(xxxiv) Number of medications;~~
- ~~(xxxv) Days received the following medications;~~
- ~~(xxxvi) Devices and restraints; and~~
- ~~(xxxvii) Overall change in care needs.~~

008.03(ED) 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 individuals 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 in cost reports.

008.04 COMPREHENSIVE CARE PLAN. The facility must 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. The plan must be:

- (A) Developed within seven days after completion of the comprehensive assessment;
- (B) Prepared by an interdisciplinary team; and
- (C) Periodically reviewed and revised by a team of qualified persons after each assessment, or at least quarterly. The plan must include recommendations of the Level II evaluation, if applicable.

008.05 ANNUAL PHYSICAL EXAMINATION. The Department requires that all nursing facility residents have an annual physical examination. The physician, based on their authority to prescribe continued treatment, determines the extent of the examination for clients based on medical necessity. For the annual physical exam, a complete blood count 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.

008.05(A) BILLING FOR THE ANNUAL PHYSICAL EXAMINATION. If the annual physical examination is performed solely to meet the Medicaid requirement, the physician must submit the appropriate professional claim to the Department. If the physical examination is performed for diagnosis or treatment of a specific symptom, illness, or injury and the client has Medicare or other third party coverage, the physician must submit the claim through the usual Medicare or other third party process.

008.06 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 must:

- (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.

008.06(A) PHYSICIAN TASKS. In accordance with 42 CFR 483.40(f), the Department will allow all but the following required physician tasks in a nursing facility 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:

- (i) Initial certification;
- (ii) Admission orders; and

(iii) Admission plan of care.

008.07 MEDICAL CARE AND SERVICES. The facility must ensure that admitted Medicaid clients receive appropriate medical care and services. If the appropriate medical care or service cannot be provided using facility staff, the facility must arrange for the care or service to be provided.

008.08 DENTAL CARE. Facilities must make arrangements for dental examinations as needed.

008.09 FREEDOM OF CHOICE. Each facility must ensure that any client may exercise their freedom of choice in obtaining covered services from any provider qualified to perform the services. Clients participating in Medicaid managed care must comply with the conditions of their managed care plan.

008.10 ROOM AND BED ASSIGNMENTS. Facility staff must 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 or medical record.

008.11 RESIDENTS' RIGHTS. The facility must protect and promote the rights of each resident as defined in 42 CFR 483.10. When the resident is unable to manage their own personal funds, and there is not a guardian or responsible family member, the facility must arrange for, or manage, the personal funds as specified in 42 CFR 483.10(c)(1) thru (8).

008.12 BED-HOLDING POLICIES FOR HOSPITAL AND THERAPEUTIC LEAVE. The facility must develop policies as defined in 42 CFR 483.15(d).

008.13 INITIAL NOTICE OF BED-HOLDING POLICIES. The facility must provide written information to the client and a family member or legal representative that specifies:

- (A) The duration of the bed-hold policy during which the client is permitted to return and resume residence in the facility; and
- (B) The facility's policies regarding bed-hold periods which must be consistent with 42 CFR 483.15(d).

008.14 NOTICE UPON TRANSFER. At the time of transfer, the facility must provide written notice to the client and a family member or legal representative which specifies the duration of the bed-hold policy.

008.15 PERMITTING THE CLIENT TO RETURN TO THE FACILITY. The facility must 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:

- (A) Requires the services provided by the facility; and
- (B) Is eligible for Medicaid nursing facility services.

008.16 FACILITY-TO-FACILITY TRANSFER. To transfer any Medicaid client from one facility to another, the transferring facility must:

- (A) Obtain physician's written order for transfer;
- (B) Obtain written consent from the client, his or her family, or guardian;

- (C) Notify the Department that handles the client's case in writing, stating:
 - (i) The reason for transfer;
 - (ii) The name of facility to which the client is being transferred; and
 - (iii) The date of transfer;
- (D) Transfer the following to the receiving facility:
 - (i) Necessary medical, social, and Preadmission Screening and Resident Review (PASSR) information;
 - (ii) Any non-standard wheelchair and wheelchair accessories, options, or components, including power operated vehicles;
 - (iii) Any augmentative communication devices with related equipment and software;
 - (iv) Supports; and
 - (v) Custom fitted or custom fabricated items; and
- (E) Document transfer information in the client's record and discharge summary.

008.17 DISCHARGES. At the time of or no later than 48 hours after a client is discharged or expires, the facility must notify the Department that handles the client's case of:

- (A) Date of discharge and the place to which the client was discharged; or
- (B) Date of death.

008.18 DISCHARGE PLANNING. Before a client's discharge or deinstitutionalization, the facility staff must document in the medical record the actual implementation date of the discharge plan. Each nursing facility must maintain written discharge planning procedures for all Medicaid clients that describe:

- (A) Which staff member of the facility has operational responsibility for discharge planning;
- (B) The manner in, and methods by, which the staff member will function, including authority and relationship with the facility's staff;
- (C) 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;
- (D) The maximum time period after which the interdisciplinary team reevaluates each client's discharge plan;
- (E) The resources available to the facility, the client, and the attending physician to assist in developing and implementing individual discharge plans; and
- (F) The provisions for periodic review and reevaluation of the facility's discharge planning program.

008.19 INAPPROPRIATE LEVEL OF CARE (LOC). If it is determined that the client's present level of care is inappropriate:

- (A) The present facility must provide services to meet the needs of the client and must refer to appropriate agencies for services until an appropriate living situation is available;
- (B) The facility must document that other alternatives were explored and the responses;
- (C) The facility must make documentation of active exploration for appropriate living situations available to the Department or their agent;
- (D) The facility must work cooperatively with the preadmission screening and resident review referral (PASRR) process.

008.20 AT THE TIME OF DISCHARGE. At the time of the client's discharge, the facility must:

- (A) 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.
- (B) Include current information on diagnosis, prior treatment, rehabilitation potential, physician advice concerning immediate care, and pertinent social information.
- (C) Discharge the following items specifically purchased for and used by the client with the client:
 - (i) Any non-standard wheelchair and wheelchair accessories, options, and components, including power operated vehicles;
 - (ii) Any augmentative communication devices with related equipment and software;
 - (iii) Supports; and
 - (iv) Custom fitted or custom fabricated items.

008.21 APPEALS OF DISCHARGES, TRANSFERS, AND PREADMISSION SCREENING AND RESIDENT REVIEW (PASSR) DETERMINATIONS. A resident of a skilled nursing facility (SNF) or a nursing facility (NF) who receives a notice from the skilled nursing facility (SNF) or nursing facility (NF) of the intent to discharge or transfer the resident may appeal to the Department of Health and Human Services for a hearing on this notice. The appeal and hearing must be conducted under 465 NAC 2 and 6. An individual who is adversely affected by any Preadmission Screening and Resident Review (PASSR) determination may appeal to the Department of Health and Human Services for a hearing on the decision. The individual or legal representative will be instructed to contact the Department or contractor for information on appeals and to forward a written request for an appeal to the Department within 90 days of the date of the Preadmission Screening and Resident Review (PASSR) determination notice. The appeal and hearing must be conducted under 465 NAC 2.

008.22 PRIOR AUTHORIZATION. Medicaid requires authorization for the following services:

- (A) Nursing facility services for clients under the age of 18;
- (B) Special needs nursing facility (NF) services;
- (C) Out-of-state nursing facilities;
- (D) Room and board services for clients receiving hospice in a special needs nursing facility (NF);
- (E) Swing bed services; and
- (F) Specialized add-on services for clients with intellectual disabilities or related conditions residing in nursing facilities.

008.23 PHYSICIAN'S INITIAL CERTIFICATION. The physician must certify the medical necessity for nursing facility level of care (NF LOC) for all admissions. Documentation indicating certification must be maintained in the medical record. The physician must also certify the medical necessity for nursing facility level of care (NF LOC):

- (A) For clients who became eligible after admission, the physician must certify medical necessity prior to requesting prior authorization for nursing facility level of care (NF LOC); and
- (B) Proof of prior authorization must be maintained in the client's medical record in the facility or building where the client resides or in the client account file.

008.24 ADMISSION HISTORY AND PHYSICAL. The client must have a physical examination within 48 hours after admission unless an examination was performed within five days before admission.

008.25 SPECIFIC PAYMENTS.

008.25(A) MEDICAID PAYMENT RESTRICTIONS FOR NURSING FACILITIES. The Department must pay for a nursing facility service only when prior authorized, when prior authorization is required.

008.25(B) INITIAL CERTIFICATION. The Department must approve payment to a facility for services rendered to an eligible client beginning on the latest date:

- (i) The client is admitted to the facility;
- (ii) The client's eligibility is effective, if later than the admission date; or
- (iii) Of the intellectual disability screen.

008.25(C) 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.

008.25(D) INAPPROPRIATE FOR NURSING FACILITY CARE. For those clients who, at the time of medical review determination, no longer meet nursing facility (NF) criteria for nursing facility (NF) services, the medical review must limit Medicaid payment for up to a maximum of 30 days, beginning with the date the medical review determines that nursing facility (NF) 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.

008.25(E) EFFECT OF PREADMISSION SCREENING AND RESIDENT REVIEW (PASSR). Medicaid payment is available for nursing facility services provided to Medicaid-eligible clients who, as a result of Preadmission Screening and Resident Review (PASSR):

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

008.25(E)(i) PREADMISSION SCREENING NOT PERFORMED. When a preadmission screening and resident review (PASSR) is not performed before admission, Medicaid payment for nursing facility services is available only for services provided after the preadmission screening and resident review (PASSR) is completed.

008.25(F) ITEMS INCLUDED IN PER DIEM RATES. The following items are included in the per diem rate:

- (i) Routine services: Routine nursing facility (NF) 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;
- (ii) Injections: The patient's physician must 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;

- (iii) Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility must provide transportation to client services that are reimbursed by Medicaid. 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;
- (iv) Contracted services: The nursing facility must contract for services not readily available in the facility:
 - (1) If the service is provided by an independent licensed provider who is enrolled in Medicaid the provider must submit a separate claim for each person served; and
 - (2) If the service is provided by a certified provider of medical care the nursing facility is responsible for payment to the provider. This expense is an allowable cost;
- (v) 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. 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.

008.25(G) ITEMS NOT INCLUDED IN PER DIEM RATES. Items for which payment may be made to nursing facility (NF) 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:

- (i) Any non-standard wheelchairs and wheelchair accessories, options, and components, including power-operated vehicles needed for the client's permanent and full time use. Standard wheelchairs are considered necessary equipment in a nursing facility to provide care and part of the per diem;
- (ii) Air fluidized bed units and low air loss bed units; and
- (iii) Negative pressure wound therapy.

008.25(H) PAYMENTS TO OTHER PROVIDERS. Items for which payment may be authorized to non-nursing facility (NF) 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:

- (i) Legend drugs, over-the-counter (OTC) drugs, and compounded prescriptions, including intravenous solutions and dilutants;
- (ii) Personal appliances and devices, if recommended in writing by a physician, such as eye glasses and hearing aids;
- (iii) Orthoses;
- (iv) Prostheses; and
- (v) Ambulance service.

008.25(I) 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:

- (i) Telephone;
- (ii) Television and radio for personal use, except cable service;
- (iii) Personal comfort items, including smoking materials, notions, and novelties, and confections;
- (iv) 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;
- (v) Personal clothing;
- (vi) Personal reading matter;
- (vii) Gifts purchased on behalf of the client;
- (viii) Flowers and plants;
- (ix) Social events and entertainment offered outside the scope of the activities program required by certification;
- (x) Non-covered special care services such as privately hired nurses or aides specifically requested by the client or family;
- (xi) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by certification; or
- (xii) Single room, except when therapeutically required.

008.25(J) OTHER. The facility must meet the following requirements:

- (i) The facility must not charge a client for any item or service not requested by the resident.
- (ii) The facility must not require a resident to request any item or service as a condition of admission or continued stay.
- (iii) The facility must inform the client 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.

008.26(K) PAYMENT FOR BED-HOLDING. The Department makes payments to reserve a bed in a nursing facility (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: nursing facility, hospital nursing facility, swing-bed, a Medicare-covered special needs facility stay, or to hospitalization following a Medicare-covered special needs facility 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, 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.

008.26(K)(i) 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 Medicaid. 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.

008.26(K)(ii) REPORTING. It is mandatory that the nursing facility (NF) report all bed-holding days monthly. Facilities must report bedholding days. The nursing home days are adjusted to the actual number of days the client was present in the facility at 12:00 midnight.

009. SPECIALIZED ADD-ON SERVICES FOR CLIENTS WITH INTELLECTUAL DISABILITIES OR RELATED CONDITIONS RESIDING IN NURSING FACILITIES.

009.01 SPECIALIZED ADD-ON SERVICES FOR CLIENTS WITH INTELLECTUAL DISABILITIES OR RELATED CONDITIONS RESIDING IN NURSING FACILITIES. Medically necessary services intended to assist the nursing facility clients in obtaining, maintaining, or improving developmental-age appropriate skills. These services include habilitative training and are not provided by the nursing facility. These services are identified through the preadmission screening and resident review (PASRR) Level II assessment. Specialized add-on services must result in a continuous, aggressive individualized plan of care and be recommended and monitored by the individual's interdisciplinary team. Each specialized add-on service must be prior authorized separately.

009.02 SPECIALIZED ADD-ON SERVICES.

009.02(A) HABILITATIVE SKILLS TRAINING. Habilitative skills training supports individuals to acquire new skills or increase skills in the areas of hygiene, self-advocacy, activities of daily living and communication. Habilitative skills can occur on-site but may be expanded to also occur in the community such as grocery stores, financial institutions, movie theatres, recreational centers or events, and social activities so the individual learns these skills in a variety of settings. Services are expected to include both formal training and opportunities to practice the skills in various settings. This service is provided with a staff to individual ratio of one to one. This service is provided to individuals in order to meet the goals and outcome measurements as outlined in the individual's plan of care. Habilitative skills training consists of:

- (1) Identification of skill needs requiring training with regard to individual rights and due process, advocating for their own needs, desires, future life goals and participation in the development of their plan of care, communication skills, personal hygiene skills, dressing skills, laundry skills, bathing skills, and toileting skills;

- (2) Development and implementation of formal training goals related to identified skill needs; and
- (3) Monitor and revise goals according to the individual's response to training.

009.02(A)(i) LIMITATIONS. Limitations are as follows:

- (1) Transportation is not included in the reimbursement rates. Transportation services can be billed separately for off-site habilitative skills only and is limited to travel to and from the habilitative service. The individual must be present in the vehicle.
- (2) This service can be authorized in combination with but cannot be provided during the same time period as habilitative community inclusion.
- (3) This service must exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the individual's local school district, including after school supervision and daytime services when school is not in session. Services cannot be provided during the school hours set by the local school district for the individual. Regular school hours and days apply for a child who receives home schooling.

009.02(B) HABILITATIVE COMMUNITY INCLUSION. Habilitative community inclusion supports individuals to increase independence and inclusion in their community. This service must occur in the community in a nonresidential setting, outside of the nursing facility (NF). Making connections with community members is a strong component of this service provision. This service is provided with a staff to individual ratio of one to one. This service is provided to individuals in order to meet the goals and outcome measurements as outlined in the individual's plan of care. Habilitative community inclusion must be included in the individual's care plan. Habilitative community inclusion services consist of:

- (1) Identification of needed skills with regard to access and use of community supports, services and activities;
- (2) Development and implementation of formal training goals related to:
 - (a) Community transportation and emergency systems;
 - (b) Accessing and participation in community groups, volunteer organizations, and social settings; and
 - (c) Opportunities to pursue social and cultural interests and building and maintaining interpersonal relationships; and
- (3) Monitoring and revising goals according to the individual's response to training.

009.02(B)(i) LIMITATIONS. Limitations are as follows:

- (1) Habilitative community inclusion can supplement, but cannot replace, activities that would otherwise be available as part of the nursing facility (NF) activities program;
- (2) Transportation is not included in the reimbursement rate and must be billed separately and is limited to travel to and from the habilitative service. The individual must be present in the vehicle; and
- (3) This service must exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA).

This includes services not otherwise available through public education programs in the individual's local school district, including after school supervision and daytime services when school is not in session. Services cannot be provided during the school hours set by the local school district for the individual. Regular school hours and days apply for a child who receives home schooling.

009.02(C) EMPLOYMENT ASSISTANCE. Employment assistance supports the individual through habilitative training to obtain gainful employment in their community. The goal is to provide the skills, tools, and supports to enable the individual to seek and obtain employment. This service is provided with a staff to individual ratio of one to one and may be provided at the nursing facility or in the community. This service is provided to individuals in order to meet the goals and outcome measurements as outlined in the individual's plan of care. Employment assistance services consist of:

- (1) Identification of the individual's job preferences and skill needs;
- (2) Identification of available employment opportunities in their community;
- (3) Development and implementation of formal training goals related to the individual's employment needs including application for employment, job readiness and preparation skills and appropriate work behavior; and
- (4) Monitoring and revising goals according to the individual's response to training.

009.02(C)(i) LIMITATIONS. Limitations are as follows:

- (1) The individual's service hours are determined by the assistance needed to reach employment goals;
- (2) This service can be authorized in combination with but cannot be provided during the same time period as employment support;
- (3) Transportation is not included in the reimbursement rate and must be billed separately and is limited to travel to and from the habilitative service. The individual must be present in the vehicle;
- (4) This service must exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the individual's local school district, including after school supervision and daytime services when school is not in session. Services cannot be provided during the school hours set by the local school district for the individual. Regular school hours and days apply for a child who receives home schooling; and
- (5) No employment assistance or support services are available to a resident of a nursing facility through a program funded by the Rehabilitation Act of 1973 in Nebraska.

009.02(D) EMPLOYMENT SUPPORT. Employment support supports the individual through habilitative training to maintain integrated and gainful employment after the individual has secured employment. The goal is to provide the skills, tools, and supports necessary for the individual to maintain employment. This service is provided with a staff to individual ratio of up to 1:4 and must be provided in the community. This service is provided to individuals in order to meet the goals and outcome measurements as outlined in the individual's plan of care. Employment Support services consist of:

- (1) Teaching appropriate work behavior related to punctuality, attendance and co-worker relationships;
- (2) Providing training and support for the individual to develop time management skills;
- (3) Providing training and monitoring in order for the individual to learn the job tasks necessary to maintain employment;
- (4) Providing social skills training in relation to the work environment; and
- (5) Monitoring and revising goals according to the individual's response to training.

009.02(D)(i) LIMITATIONS. Limitations are as follows:

- (1) Payment for employment support excludes the supervisory activities rendered as a normal part of the business setting.
- (2) This service can be authorized in combination with but cannot be provided during the same time period as employment assistance.
- (3) Transportation is not included in the reimbursement rate and must be billed separately and is limited to travel to and from the habilitative service. The individual must be present in the vehicle.
- (4) This service must exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the individual's local school district, including after school supervision and daytime services when school is not in session. Services cannot be provided during the school hours set by the local school district for the individual. Regular school hours and days apply for a child who receives home schooling.
- (5) No employment assistance or support services are available to a resident of a nursing facility through a program funded by the Rehabilitation Act of 1973 in Nebraska.

009.02(E) NON-MEDICAL TRANSPORTATION. Non-medical transportation is provided in order for the individual to participate in specialized add-on services in a community setting.

009.02(E)(i) LIMITATIONS. Limitations are as follows:

- (1) Transportation is limited to travel to and from a habilitative service according to the individual's plan of care.
- (2) The individual must be present in the vehicle.
- (3) Purchase or lease of vehicles is not covered under this service.
- (4) Is a separately billable service for off-site habilitative skills, off-site employment assistance, employment support, and habilitative community inclusion.

009.02(F) PRIOR AUTHORIZATION. For each specialized add-on service prior authorization request must be submitted by the person or agency providing the service. Medicaid must receive the prior authorization request within 15 calendar days of the start date of the service. The person or agency must provide the following as part of the prior authorization process:

- (1) The individual or resident's Level II preadmission screening and resident review (PASRR) final summary determination which must include the recommended specialized add-on services;

- (2) The individual or resident's plan of care which must include these specialized add-on services;
- (3) Specify the formal goals and objectives that address the individual or resident's needs determined in the Level II preadmission screening and resident review (PASSR) final summary; and
- (4) The frequency and duration of the service.

009.02(i) ADDITIONAL REQUIREMENTS. Specialized add-on services are provided only when prior authorized, recommended by the client's interdisciplinary team and are included in the client's plan of care. The interdisciplinary team includes but is not limited to the attending physician, a registered nurse and nurse aide with responsibility for the individual, a member of the food and nutrition services staff, to the extent possible the individual and the individual's representative, and other appropriate staff or professionals in disciplines as determined by the individual's needs or as requested by the individual. Specialized add-on services must meet professional standards of quality and be provided by qualified persons in accordance with each individual's written plan of care.

009.02(ii) PAYMENTS. Specialized add-on services are paid to the providers of specialized add-on services. Payments to providers for medically necessary services, including specialized add-on services in excess of limitations for covered services identified elsewhere in the state plan, or not listed as specialized add-on services according to the state plan, require pre-authorization.

010. SERVICES FOR LONG TERM CARE CLIENTS WITH SPECIAL NEEDS.

010.01 LONG TERM CARE CLIENTS WITH SPECIAL NEEDS. Long term care clients with special needs means those whose medical or 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.

010.01(A) 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 registered nurse nursing coverage.

010.01(A)(i) CRITERIA FOR CARE. The client must:

- (1) Require intermittent, but not less than 10 hours in a 24-hour period, or continuous ventilator support. They are 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 (Bi-PAP) nasally. Patients requiring use of Bi-level positive airway pressure 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;
- (4) Require daily respiratory therapy intervention or modality support; and
- (5) Have needs that cannot be met at a lesser level of care.

010.01(B) CLIENTS WITH BRAIN INJURY.

010.01(B)(i) 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; 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 Nebraska Medicaid.

010.01(B)(i)(a) CRITERIA FOR CARE. The client must:

- (i) Require physician services that exceed those described in 471 NAC 12-008.06;
- (ii) 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:
 - (1) Complex medical needs as well as extended training or rehabilitation needs that together exceed the criteria for nursing facility level of care;
 - (2) Combinations of extended training or rehabilitative needs that together exceed the criteria for nursing facility level of care;
 - (3) Extended training or rehabilitation needs that require multi-disciplinary care; or
 - (4) Complex combinations of needs from various domains.
- (iii) Be capable of participating in an extended training or rehabilitation program evidenced by:
 - (1) Ability to tolerate a full rehabilitation schedule daily;
 - (2) Being medically stable and free from complicating acute major medical conditions that would prohibit participation in an extended rehabilitation program;
 - (3) Possessing the cognitive ability to communicate some basic needs, either verbally or non-verbally;
 - (4) 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, or memory impairment, minimum Level IV on the Rancho Los Amigos Coma Scale; or
 - (5) Being absent of addictive habits or behaviors that would inhibit successful participation in the training or rehabilitation program;
- (iv) 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:
 - (1) Possessing a current documented prognosis that indicates that the individual has the potential to successfully complete an extended training or rehabilitation program;
 - (2) 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
- (3) Documentation supporting that they are making continuous progress in an extended training or rehabilitation program including transitional training for successful discharge or transfer.

010.01(B)(ii) 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 as evidenced by:
 - (a) Combinations of medical, care or rehabilitative needs that together exceed the criteria for nursing facility level of care;
 - (b) Care that requires a specially trained, multi-disciplinary team;
 - (c) Complex care needs occurring in combinations from various domains; 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; and
 - (b) Being absent of addictive habits 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 or events;
 - (b) Being able to tolerate open and stimulating environment;
 - (c) Being able to establish or tolerate routines;
 - (d) Being able to communicate verbally or non-verbally basic needs; and
 - (e) Requiring moderate to extensive assistance to preserve acquired skills.

010.01(C) OTHER SPECIAL NEEDS CLIENTS. These clients must require complex medical or 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, or therapies. The client must meet the criteria for one of the two following categories:

010.01(C)(i) CRITERIA FOR CARE OF CLIENTS WITH REHABILITATIVE SPECIAL NEEDS. The client must:

- (1) Be medically stable and require physician services two to three times per week;
- (2) Require multi-disciplinary care;
- (3) Require care in multiple body organ systems;
- (4) Require a complicated medical or 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 or interventions more frequently than every six hours with other complex care needs;

- (f) Initiation of Continuous Abdominal Peritoneal Dialysis (CAPD) or established Continuous Abdominal Peritoneal Dialysis 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 or equipment;
- (6) Have professional documentation supporting that they are 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.

010.01(C)(ii) CRITERIA FOR CARE OF PEDIATRIC CLIENTS WITH SPECIAL NEEDS. The client must:

- (1) Be under age 21;
- (2) Be medically stable;
- (3) Require multidisciplinary care; and
- (4) Require a complex medical or treatment regimen requiring observation and intervention by specially trained professionals, such as:
 - (a) Tracheostomy care or 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 or 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.

010.01(D) EXCEPTION. Under extenuating circumstances, the Department may approve an exception to the criteria for care of long term care clients with special needs.

010.02 FACILITY QUALIFICATIONS. To be approved as a provider of services for long term care 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 participate in the Nebraska Medical Assistance Program. 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 as found in 471 NAC 1. The facility must demonstrate the capacity or 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. The facility must have the ability to provide the necessary professional services as the client requires. The facility must:

- (A) Demonstrate the capability to provide highly skilled multidisciplinary care;
- (B) Ensure that its staff have received appropriate training and are competent to care for the identified special needs population that is being served;
- (C) Be able to provide the necessary professional services that the special needs clients require;
- (D) Have the physical plant adaptations necessary to meet the client's special needs;
- (E) Establish admission criteria and discharge plans specific to each special needs population being served;

- (F) Have a separate and distinct unit for the special needs program;
- (G) Establish written special program criteria with policy and procedures to meet the needs of an identified special needs group as defined in this chapter;
- (H) Have written policies specific to the special needs unit regarding:
 - (i) Emergency resuscitation;
 - (ii) Fire and natural disaster procedures;
 - (iii) Emergency electrical back-up systems;
 - (iv) Equipment failure;
 - (v) Routine and emergency laboratory or radiology services; and
 - (vi) Emergency transportation.
- (I) Maintain the following documentation for special needs clients:
 - (i) 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 this chapter. The initial assessment and the team's review and decisions for care must be retained in the client's permanent record;
 - (ii) 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;
 - (iii) A minimum of daily documentation or assessment or intervention by a Registered Nurse or other professional staff as dictated by the client's needs;
 - (iv) A record of physician's visits; and
 - (v) 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, or deletions to the established program plan;
- (J) Maintain financial records; and
- (K) 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 and Medicaid for nursing facility certification.

010.03 APPROVAL PROCESS. Nebraska Medicaid pays for a special need nursing facility service when prior authorized. Each admission shall be individually prior authorized.

010.03(A) PRIOR TO ADMISSION. A written comprehensive and individualized assessment completed by the facility must be sent to the Department. The assessment and accompanying documentation must address how the client meets the criteria for special needs care as defined in this chapter. It is the facility's responsibility to assess, gather and obtain this information and submit it to the Department for prior authorization and before admission. Initial approval or 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 Department. The initial approval will be delayed until all information is received by the Department. The Pre-Admission Screening Level I Screen and Level II Evaluation, when applicable, must be completed before admission and the Level II findings and reports must accompany the packet of information sent to the Department for funding authorization.

010.03(A)(i) OTHER CLIENTS. Facilities serving the needs of individuals who are ventilator-dependent and other special needs clients must include the individualized admission assessment completed by the facility and other documentation which must include:

- (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 of any facility stays within the past 6 months;
- (4) Current physical, cognitive, or behavioral status;
- (5) Justification for special needs level of care; and
- (6) Identification of major areas of preliminary care planning and an estimate of services needed to reach the proposed goals.

010.03(A)(ii) BRAIN INJURIES. Facilities serving the needs of clients with brain injuries shall submit the individualized admission assessment completed by the facility and the following documentation which must include:

- (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 stays within the past year;
- (4) All discharge or service summaries of any rehabilitative 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 (IEP) and discharge statement or 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, or behavior status; and
- (9) Identification of major areas of preliminary care planning and an estimate of services needed to reach the proposed goals.

010.03(B) INITIAL APPROVAL. Based on the pre-admission assessment, initial approval or denial will be given by the Department 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 Department 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 Department 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.

010.03(B)(i) 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:

- (1) Complete an admission Form MC-9-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 Department.

010.03(B)(i)(a) ASSESSMENT. Facility staff must make a comprehensive assessment of the resident's needs within 14 days of admission, using the Minimum Data Set (MDS), and transmit it electronically to the Department.

010.03(B)(i)(b) APPROVAL. The Department 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.

010.03(B)(ii) 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:

- (1) Complete an admission Form MC-9-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 Minimum Data Set; and
- (5) Submit all information to the Department.

010.03(B)(ii)(a) APPROVAL. The Department 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.

010.04 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 this chapter. The Department will notify the facility in writing of this finding.

010.04(A) COMPREHENSIVE PLAN OF CARE. The facility must submit copies of the initial comprehensive plan of care and subsequent interdisciplinary team meetings that document the client's progress or lack of progress toward the client's established program outcomes or goals to the Department quarterly.

010.04(A)(i) MONTHLY REVIEWS. Nebraska Medicaid requires monthly reviews for extended brain injury rehabilitation stays beyond two years.

010.04(A)(ii) RIGHT TO CONTEST A DECISION. See 471 NAC 2.

010.05 PAYMENT FOR SERVICES FOR LONG TERM CARE CLIENTS WITH SPECIAL NEEDS. Payment for services to all special needs clients must be prior authorized by the Department.

010.05(A) 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.

010.06 ALL REQUIREMENTS APPLY. The requirements of 471 NAC 12 apply to services provided under 471 NAC 12.010 unless otherwise specified in 471 NAC 12.010.

010.07 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. Services for special needs children are a skilled level of care provided by a certified Home Health agency, licensed registered nurses or licensed practical nurses. These providers must have necessary training and experience in the care of ventilator-dependent, pulmonary, 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 or 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 or continual observation on an on-going basis;
- (2) Pulmonary Clients: These clients must require complex respiratory or medical care, in combinations which exceed the needs of the skilled nursing client. These clients may also use excessive amounts of supplies and equipment; or
- (3) Other Special Needs Clients: The clients must require complex medical or rehabilitative care in combinations, which exceed the requirements of the skilled nursing client. These clients may also use excessive amounts of supplies, equipment, or therapies.

010.07(A) APPROVAL. Department approval for this level of care is required.

010.08 INTERMEDIATE SPECIALIZED SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS. Nebraska Medicaid covers intermediate specialized services (ISS) for persons with serious mental illness. Intermediate Specialized Services (ISS) are covered for those individuals who have been identified by the Level II Preadmission Screening and Resident Review (PASSR) evaluation and through the Intermediate Specialized Services (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 add-on services" is defined by Preadmission Screening and Resident Review (PASSR) regulations in this chapter. These individuals need more support than nursing facilities would normally provide, but not at a "specialized services" level.

010.08(A) ALL REQUIREMENTS APPLY. The requirements of 471 NAC 12 apply to Intermediate Specialized Services (ISS) providers unless otherwise specified.

010.08(B) INTERMEDIATE SPECIALIZED SERVICES (ISS) FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS. Intermediate Intensive Treatment 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:

- (i) The client's regular participation, in accordance with their comprehensive care plan, in professionally developed and supervised activities, experiences, and therapies; ~~and~~
- (ii) 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.

010.08(C) PROGRAM COMPONENTS. Intermediate Specialized Services (ISS) is designed to:

- (i) Provide and develop the necessary services and supports to enable clients to reside successfully in a nursing facility without the need of more intensive services;
- (ii) Maximize the client's participation in community activity opportunities, and improve or maintain daily living skills and quality of life;
- (iii) Facilitate communication and coordination between any providers that serve the same client;
- (iv) Decrease the frequency and duration of hospitalization and inpatient mental health (MH) services;
- (v) 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;
- (vi) 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;
- (vii) 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;
- (viii) Monitor client progress in the services being received and facilitate revision to the comprehensive care plan as needed;
- (ix) 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;

- (x) 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
- (xi) 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.

010.08(D) CRITERIA FOR ISS. For Intermediate Specialized Services (ISS), the client must have been evaluated through the Preadmission Screening and Resident Review (PASSR) process and the Intermediate Specialized Services (ISS) evaluation process, and been determined to not need intensive treatment services based on the outcomes of the Level II evaluation and the Intermediate Specialized (ISS) Services Evaluation Process. The Intermediate Specialized Services (ISS) Evaluation Process must include 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 except DSM "V" codes, substance use disorders, developmental disorders, and dementia which are excluded, unless they co-occur with another diagnosable serious mental illness.

010.08(E) COMPREHENSIVE CARE PLAN DEVELOPMENT. The Department or its designee will refer clients authorized for Intermediate Specialized Services (ISS) to the most appropriate providers, consistent with client choice. The Intermediate Specialized Services (ISS) provider must work with the client to complete a comprehensive care plan that includes:

- (i) An assessment of the client's strengths and needs in that service domain according to the requirements of the Level II evaluation and the Intermediate Specialized Services evaluation process; and
- (ii) The Resident Assessment.

010.08(F) MOVEMENT BETWEEN INTENSIVE TREATMENT SERVICES, INTERMEDIATE 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 intensive treatment services or marked decrease in the need for Intermediate Specialized Services (ISS).

010.08(F)(i) INCREASE IN SERVICE NEEDS. Nursing facility staff must request review by the consulting psychiatrist when Intermediate Specialized Services (ISS) are not sufficient to meet a client's needs. Based on the findings of the consulting psychiatrist, the client may be moved to an inpatient facility for receipt of intensive treatment services.

010.08(F)(i)(1) RETURNING FROM RECEIVING INTENSIVE TREATMENT SERVICES FOR MENTAL ILLNESS. For Intermediate Specialized Services (ISS)

clients, this process must follow procedures at 471 NAC 12-007.09(A) and 12-010.08(D).

010.08(F)(ii) DECREASE IN SERVICE NEEDS. When the need for Intermediate Specialized Services (ISS) decreases, regular services that the nursing facility would normally provide may be sufficient. In addition to the normal discharge planning process, Intermediate Specialized Services (ISS) facility staff must request review by the Intermediate Specialized Services (ISS) evaluation team. With the team's approval, the client may be transferred to regular nursing facility services.

010.08(G) TRANSFERS. For Intermediate Specialized Services (ISS) clients, transfers between nursing facilities will not require a Level I screen or Level II Preadmission Screening and Resident Review (PASSR) evaluation. A Tracking Form must be completed and faxed to the Department for clients with a Preadmission Screening and Resident Review (PASSR) determination.

010.08(H) STANDARDS FOR PROVIDER PARTICIPATION. Intermediate Specialized Services (ISS) providers may be any nursing facility certified to participate in Medicaid and Medicare. If the Intermediate Specialized Services (ISS) provider subcontracts with service providers, they must be Medicaid enrolled providers. All providers of Intermediate Specialized Services (ISS) must be approved and meet all applicable requirements under Title 471 NAC 2, Provider Participation and other applicable sections of the NAC. However, for the purposes of effectiveness and efficiency in delivering these services, the Department approves Intermediate Specialized Services (ISS) providers through a proposal process, and certifies all or part of a facility to provide Intermediate Specialized Services (ISS). The Department will announce, through public notice, when it will entertain facility proposals. These announcements will detail to potential Intermediate Specialized Services (ISS) providers the primary locations, number of beds, architectural standards, staffing requirements, and any other information to assist facilities with their proposals.

010.08(I) 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 Intermediate Specialized Services (ISS) and related mental health services. At a minimum, the Intermediate Specialized Services (ISS) facility must have a consulting psychiatrist. It must develop and implement a comprehensive care plan for each Intermediate Specialized Services (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.

010.08(I)(i) 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 Intermediate Specialized Services and related mental health services; and
- (3) It maintains evidence of the staff having appropriate license, certification, registration, or credential.

010.08(I)(ii) INITIAL ORIENTATION. The facility must provide staff with orientation before the staff person having direct responsibility for care and treatment of clients receiving Intermediate Specialized Services (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) Cardiopulmonary resuscitation and medical first aid; and
- (11) Strength-based services and the recovery model.

010.08(I)(iii) DOCUMENTATION. The facility must maintain documentation of staff initial orientation and training.

010.08(I)(iv) 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.

010.08(J) CLIENT RIGHTS. The facility must ensure that clients rights are ensured in accordance with 42 CFR 483.10 and 175 NAC 12.

010.08(K) UTILIZATION REVIEW. The Department or its designee will provide utilization review for Intermediate Specialized Services (ISS). This includes assessing the appropriateness of the intensity of services and providing 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 Intermediate Specialized Services (ISS), and will review and approve new service recommendations and continued eligibility for Intermediate Specialized Services (ISS).

010.08(L) PAYMENT. The Department pays for Intermediate Specialized Services (ISS) as specified in this chapter.

011. MEDICAID HOSPICE BENEFIT.

011.01 STANDARDS FOR PARTICIPATION. To participate in Medicaid, a hospice must 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.

011.01(A) PROVIDER ENROLLMENT. To complete the provider enrollment process, the hospice must meet the following conditions:

- (i) The hospice must have a signed, written and non-resident-specific contract with each certified nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD); and
- (ii) The hospice must complete and submit a Medicaid provider agreement in entirety to Medicaid for each contracted nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD).

011.02 COVERED SERVICES. Nebraska Medicaid must pay the hospice for the client's room and board in the facility when the following conditions are met:

- (1) The hospice and the facility must have a written agreement under which the hospice is responsible for the professional management of the client's hospice care;
- (2) The client must be eligible for Medicaid benefits;
- (3) The client must have elected to receive the Medicare or Medicaid hospice benefit;
- (4) The client must reside in a Medicaid-certified bed in the facility;
- (5) Prior authorization requirements must be met;
- (6) The client is an adult; and
- (7) The preadmission screening and resident (PASRR) review must be completed before the client is admitted to the facility.

011.02(A) COVERED SERVICES FOR CHILDREN. Nebraska Medicaid must pay the facility for the client's room and board expense in a nursing facility (NF) or intermediate care facility for individuals with developmental disabilities (ICF/DD) if the client is a child 18 years old or younger.

011.03 PRIOR AUTHORIZATION REQUIREMENTS. The following steps must be completed before Medicaid authorizes room and board payment to the hospice:

- (1) The hospice must obtain prior authorization for the actual hospice service when Medicaid is the primary payer;
- (2) The hospice must obtain prior authorization for special needs and out-of-state nursing facility payment by paper or electronically. An MC-9NF or Nursing Facility Level of Care Determination Form must be submitted with attachments according to the requirements listed in this chapter;
- (3) The hospice contracted nursing facility (NF) must comply with all assessment requirements as stated in this chapter. For intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care (LOC) see 471 NAC 31;
- (4) For a new admission to a nursing facility (NF), the hospice must submit the following to Medicaid:
 - (a) Nebraska Level I Preadmission Screening and Resident Review (PASRR) form;
 - (b) Form MC-9NF, or Nursing Facility Level of Care (NF LOC) Determination Form;
 - (c) A copy of the DM-5 or history and physical;
 - (d) The hospice plan of care and certification;

- (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 (NF), the hospice must complete and submit to Medicaid:
 - (a) Form MC-9NF, or Nursing Facility Level of Care Determination Form;
 - (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.

011.03(A) PRIOR AUTHORIZATION EXCEPTION. When a client is eligible for the Medicare hospice benefit, prior authorization for the nursing facility (NF) room and board, not a Medicare hospice benefit, is not required for payment by Medicaid with the exception of out-of-state and special needs residents as identified in this chapter.

011.03(B) REQUIRED ASSESSMENTS. The hospice contracted nursing facility must comply with all assessment requirements as stated in this chapter.

011.04 PAYMENT TO THE HOSPICE. Medicaid's payment to the hospice must be based on the rate established by the Department for the nursing facility (NF) in which the client resides, based on the assessment for each individual. The hospice must make payment to the nursing facility (NF) for the client's room and board according to the contract between the facility and the hospice.

011.05 BILLING. The hospice must bill the Department on the appropriate claim form or electronic format.

011.05(A) NURSING FACILITY BILLING. The nursing facility (NF) must not bill Medicaid for room and board for any adult client that has elected to receive the hospice benefit.

011.05(A)(i) EXCEPTION. The nursing facility (NF) must continue to bill Medicaid for room and board for clients under the age of 18.

012. CIVIL MONEY PENALTY (CMP).

012.01 COLLECTION AND USE OF CIVIL MONEY PENALTY (CMP) FUNDS. The Nebraska Civil Money Penalty (CMP) Program is administered by the Department in accordance with Section 1919(h)(3)(C)(ii)(IV)(ff) of the Social Security Act, 42 CFR 488.400 through 488.456 and Nebraska Revised State Statutes 71-2097 to 71-20,101.

012.01(A) ASSESSMENT OF PENALTY. The Division of Public Health of the Department of Health and Human Services is authorized to act as the survey and certification agency for the Medicaid program pursuant to Neb. Rev. Stat. 81-604.03. The Division of Public Health notifies the Department of any violation by a nursing facility (NF), as defined in Neb. Rev. Stat. 71-2097. Civil penalties will be determined pursuant to Neb. Rev. Stat. 71-2097 to 71-20,101. Upon the recommendation of the Civil Money Penalty (CMP), the Department issues a certified letter to the provider according to 42 CFR 488.434.

012.01(B) APPEAL. See 471 NAC 2.

012.02 CIVIL MONEY PENALTY (CMP) EMERGENCY PAYMENTS. Civil money penalty (CMP) funds collected by the State are applied to actions for the protection of the health or property of nursing facility residents.

012.02(A) EMERGENCY FUND REASONS. Funds may be allocated for the following reasons:

- (i) To cover payment for the non-reimbursed costs of protecting residents or relocating residents to other facilities in the event of a qualifying natural disaster or nursing facility (NF) closure;
- (ii) State costs related to the operation of a facility pending correction of deficiencies or closure;
- (iii) Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents; and
- (iv) Other activities that benefit nursing home residents as provided in 42 C.F.R. 488.433.

012.02(B) NURSING FACILITY (NF) CONTINGENCY TEAM. Upon notification to the nursing facility (NF) contingency team of the existence of an emergency situation the contingency team convenes. The team includes the Division of Public Health Licensure Unit, Office of Long Term Care Facilities, a representative from Medicaid, the State Long Term Care Ombudsman, a representative from the Nebraska Department of Health and Human Services Public Relations, and the Department legal counsel for Long Term Care Facilities. The team considers the situation and options and recommends access to funds for the relocation of residents or the maintenance of facility operations until such a time as relocation can occur.

012.02(C) FINAL APPROVAL FOR USE OF CIVIL MONEY PENALTY (CMP) FUNDS. The final determination to submit the request to Centers for Medicare and Medicaid Services (CMS) for use of Civil Money Penalty (CMP) funds is made by the Department Chief Executive Officer (CEO). Per CFR 42 488.433 (b) all activities and plans for utilizing Civil Money Penalty (CMP) funds, including any expense used to administer grants utilizing Civil Money Penalty (CMP) funds, must be approved in advance by Centers for Medicare and Medicaid Services (CMS).

012.03 CIVIL MONEY PENALTY GRANT FUNDING. This program is funded through the collection of Civil Money Penalties (CMPs) imposed against nursing facilities as a result of survey deficiencies. Eligible applicants must apply for grant funding during the designated application period and submitting it as directed by the Department.

012.03(A) ELIGIBLE APPLICANTS. Civil Money Penalty (CMP) grant funding may be requested by eligible stakeholders, which include:

- (i) Nebraska Medicaid-participating nursing facilities and their residents;
- (ii) Professional and state nursing facility (NF) associations and advocacy groups;
- (iii) Consumer advocacy organizations;
- (iv) Resident or family councils;

- (v) Nursing facility (NF) resident quality improvement organizations; private contractors; and
- (vi) Other groups approved by Medicaid indicating an interest in the care and well-being of nursing facility (NF) residents.

012.03(B) ELIGIBLE PROJECTS. Civil Money Penalty (CMP) grant funding is considered for the following projects:

- (i) Culture change;
- (ii) Resident or family councils;
- (iii) Direct improvements to quality of care or resident protection;
- (iv) Quality improvement activities or resources;
- (v) Consumer information; and
- (vi) Training in facility improvement initiatives for staff to:
 - (1) Improve performance; or
 - (2) Develop new or innovative approaches to improve the quality of life and care for residents.

012.03(C) PROHIBITED USE OF CIVIL MONEY PENALTY (CMP) FUNDS. Civil Money Penalty (CMP) fund requests will not be considered if any of the following apply:

- (i) Conflict of interest or the appearance of a conflict of interest;
- (ii) Long-term projects, with a duration greater than 3 years;
- (iii) Duplication of payment that is already appropriated from state or federal sources;
- (iv) Capital improvement projects;
- (v) Temporary manager salaries; or
- (vi) Ineligible recipients. This includes nursing facilities (NFs) who were cited with an immediate jeopardy (IJ) violation or harm at deficiency level H or I during their previous standard survey. Any exceptions must be approved through Centers for Medicare and Medicaid Services (CMS).

012.03(D) GRANT FUND DETERMINATION. Designated Medicaid and Public Health staff review grant applications based upon compliance with Civil Money Penalty (CMP) laws and regulations. The final decision is made by the Director of Medicaid. Final approval is granted by Centers for Medicare and Medicaid Services (CMS).

013. RATE METHODOLOGY. The Department will make the currently utilized rate methodology publicly available.

013.01 PUBLIC MEETING. The Department will hold a public meeting whenever making changes to the rate methodology. It will conform to the below requirements:

- (A) The Department will hold a public meeting no later than 90 days prior to the proposed effective date of any changes to the rate methodology; and
- (B) The Department will provide public notice of the proposed changes to the rate methodology at least 30 days prior to the public meeting. This public notice will include proposed updates to the rate methodology.

014. NURSE AIDES IN NURSING FACILITIES.

014.01 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:

- (A) That individual is competent to provide nursing and nursing-related services;
- (B) 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;
- (C) The nurse aide has met the requirements set out in Neb. Rev. Stat. ~~Section~~§ 71-6038 and 6039; and
- (D) The nurse aide has not:
 - (i) Been found guilty of abusing, neglecting, or mistreating residents by a court of law; or
 - (ii) 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 this chapter.

014.02 FACILITY RESPONSIBILITY.

014.02(A) REGISTRY VERIFICATION. Before allowing an individual to serve as a nurse aide, a facility must contact the State nurse aide registry and verify that the individual has met competency evaluation requirements unless:

- (i) The individual is a full-time employee currently participating in a training and competency evaluation program approved by the State; or
- (ii) The individual can prove that he or she 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 must follow up to ensure that the individual actually becomes registered.

014.02(B) MULTI-STATE REGISTRY VERIFICATION. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State nurse aide registry the facility believes will include information on the individual.

014.02(C) DUTY TO REPORT. A facility must 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.

014.03 NURSE AIDE REQUIREMENTS.

014.03(A) 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.

014.04 ESTABLISHMENT OF NURSE AIDE REGISTRY.

014.04(A) 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. 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 and 172 NAC 108.

014.04(B) REGISTRY ELIGIBILITY. The registry must comply with the following:

- (i) To be included on the nurse aide registry as eligible to function as a nurse aide, an individual must meet the requirements in this chapter;
- (ii) An individual may be deemed or determined competent for eligibility for placement on the registry as provided in 42 CFR 483.150;
- (iii) 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
- (iv) No monetary charges related to registration of individuals on the registry are imposed.

014.04(C) 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 this chapter:

- (i) The individual's full name;
- (ii) Information necessary to identify each individual;
- (iii) The date the individual became eligible for placement in the registry;
- (iv) With a finding of abuse, neglect, or misappropriation of property by the individual, the following information is included, this information must be 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:
 - (1) Documentation of the investigation, including the nature of the allegation and the evidence that led to the conclusion that the allegation was valid;
 - (2) If the individual chose to have a hearing, its date and outcome; and
- (v) If the individual chooses to dispute the allegation, their statement;
- (vi) Information related to the provisions of 471 NAC 12-012.04(A), items 3 and 4a; and
- (vii) Documentation of the ineligibility of individuals who have performed no nursing or nursing-related services for a period of 24 consecutive months.

014.04(D) REMOVAL OF REGISTRY CONTENT.

014.04(D)(i) REMOVAL OF FINDINGS OF NEGLECT FROM NURSE AIDE REGISTRY. In the case of a finding of neglect under this chapter, a nurse aide may petition 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;
- (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.

014.04(D)(ii) 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; and
- (5) Information regarding any education or rehabilitation efforts that the individual has completed since the finding of neglect was placed on the registry.

014.04(D)(iii) 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 their employment as a nurse aide that resulted in any employment action including counseling;
- (2) 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 which has not been overturned, or any conviction of any crime involving violence or the threat of violence.

014.04(D)(iv) REVIEW OUTCOME. Based on factors identified above, 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.

014.04(D)(v) NOTIFICATION. Conditions for notification.

014.04(D)(v)(1) REMOVAL. 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.

014.04(D)(v)(2) ADDITIONAL ACTIONS. If the State survey and certification agency determines the findings of neglect should not be removed from the registry or that additional actions are required for removal, 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 this chapter.

014.04(D)(v)(3) PERMANENT FINDINGS. 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.

014.04(E) DISCLOSURE OF INFORMATION. The date the individual became eligible for placement in the registry, documentation of any investigation, including the nature of the allegation and the evidence that led to the conclusion that the allegation was valid, if there was a hearing its date and outcome, and if the individual disputes the allegation their statement, is disclosed to all requesters. This information is:

- (i) Provided to the individual affected when adverse findings on them are placed in the registry, or
- (ii) Provided to the individual upon their request. Individuals on the registry must have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

014.05 INVESTIGATION OF COMPLAINTS AND PLACEMENT OF ADVERSE FINDINGS.

014.05(A) 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. 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.

014.05(B) 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.

014.05(B)(i) 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; and
- (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.

014.05(C) CONDUCT OF THE HEARING AND JUDICIAL REVIEW. The hearing is conducted under the following provisions:

- (i) 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;
- (ii) The hearing is held at a reasonable place and time convenient for the individual;
- (iii) The hearing will be conducted in accordance with the provisions of the Nebraska Administrative Procedures Act; and
- (iv) 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.

014.05(D) 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.

014.05(E) 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:

- (i) The individual;
- (ii) The current administrator of the facility in which the incident occurred;
- (iii) The administrator of the facility that currently employs the individual, if different than the facility in which the incident occurred;
- (iv) The licensing authority for individuals used by the facility other than nurse aides, if applicable; and
- (v) The nurse aide registry for nurse aides. The findings must be included in the registry within 10 working days of the findings.

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 43 NURSING FACILITY LEVEL OF CARE DETERMINATION FOR CHILDREN

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq. (the Medical Assistance Act).

002. DEFINITIONS. The definitions set out in Neb. Rev. Stat. § 68-907 and the following definitions apply:

002.01 ACTIVITIES OF DAILY LIVING (ADL). Activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

002.02 AGE APPROPRIATE. Reflective of the developmental abilities of the child taking into account any cultural traditions that are within the boundaries of state and federal law.

002.03 BATHING. A person's ability to take a full-body bath or shower. Includes how a person transfers in and out of tub or shower and the ability to bathe each part of the body.

002.04 DRESSING. A person's ability to put on and remove clothing from upper and lower body. This includes the ability to put on or remove physician ordered prosthetic or orthotic devices.

002.05 EATING. A person's ability to eat and drink. Includes intake of nourishment by other means, such as tube feeding or total parenteral nutrition.

002.06 PERSONAL HYGIENE. A person's ability to manage personal hygiene including combing hair, brushing teeth, and washing and drying self.

002.07 HOME AND COMMUNITY-BASED WAIVER SERVICES FOR AGED PERSONS OR ADULTS OR CHILDREN WITH DISABILITIES. An array of community-based services available to individuals who are eligible for nursing facility (NF) services under Medicaid but choose to receive services at home. The purpose of the waiver services is to offer options to Medicaid clients who would otherwise require nursing facility (NF) services.

002.08 HOSPICE. Hospice or hospice services shall meet the definition in 471 Nebraska Administrative Code (NAC) 36.

002.09 LEGAL REPRESENTATIVE. 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.

002.10 LEVEL OF CARE (LOC) DETERMINATION. Medicaid's nursing facility (NF) screening for medical necessity.

002.11 LIMITATION. A person is determined to have a limitation if they have difficulty performing age appropriate tasks associated with an activity of daily living by himself or herself, or is unable to perform the activity of daily living at all.

002.12 LEVEL II EVALUATION. See 471 NAC 12.

002.13 MEDICAID-ELIGIBLE. See 471 NAC 12.

002.14 MOBILITY. The ability to move from place to place indoors or outside, walking or other locomotion between locations on the same floor on a building.

002.15 NURSING FACILITY (NF). See 471 NAC 12.

002.16 REHABILITATION. See 471 NAC 12.

002.17 REHABILITATIVE SERVICES. See 471 NAC 12.

002.18 TERMINALLY ILL OR TERMINAL ILLNESS. The client is diagnosed with a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

002.19 TOILETING. How a person uses the toilet room, commode, bedpan, or urinal. How a person cleanses self after toilet use or incontinent episode(s), manages ostomy or catheter, and adjusts clothes.

002.20 TRANSFERRING. The ability to move from one place to another, including bed to chair and back, and into and out of a vehicle. Includes the ability to move on and off toilet or commode.

003. LEVEL OF CARE.

003.01 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). In order to make a determination, the client or representative must be assessed on the basis of activities of daily living (ADLs), risk factors, medical conditions and interventions, and cognitive function, to be determined via in-person discussion and observation of the client; reports from caregivers, family, and providers; and current medical records.

003.01(A) 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 0-47 Months: To be eligible, the child must have needs related to a minimum of one defined medical condition or treatment as listed in this chapter; and
- (2) Children age 48 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 or treatment need;
 - (b) Limitations in at least six activities of daily living (ADL); or
 - (c) Limitations in at least four activities of daily living (ADL) and the presence of at least two other considerations.

003.01(A)(i) AGE. 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.

003.01(A)(ii) LEVEL OF CARE (LOC) CRITERIA. The client or his or her authorized representative must provide the nursing facility level of care (NF LOC) information for use in the level of care determination which is obtained through in-person discussion, standardized assessment, and observation of the child; reports from parents or legal representative or 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.

003.01(A)(ii)(1) DETERMINATION OF MEDICAL CONDITIONS AND MEDICAL TREATMENTS. To qualify with a limitation in this category, a child must have a defined, documented medical condition or receipt of treatment, which satisfies the requirements of this chapter.

003.01(A)(ii)(1)(a) DEFINED MEDICAL TREATMENT AND MEDICAL CONDITIONS. The following medical conditions and treatments are considered in determining nursing facility level of care (NF LOC) eligibility:

- (i) Defined medical treatments:
 - (1) Chemotherapy;
 - (2) Hemodialysis;
 - (3) Peritoneal dialysis;
 - (4) IV medication;
 - (5) Routine oxygen therapy;
 - (6) Radiation;
 - (7) Nasopharyngeal suctioning;
 - (8) Tracheotomy care;
 - (9) Transfusion;
 - (10) Ventilator or respirator;
 - (11) Wound care;
 - (12) Urinary catheter care;
 - (13) Continuous positive airway pressure (CPAP) or bi-level positive

- airway pressure (BiPAP);
- (14) Percussion vest;
- (15) Urinary collection device;
 - (a) Condom catheter;
 - (b) Indwelling catheter; or
 - (c) Cystostomy, nephrostomy, ureterostomy;
- (16) Inadequate pain control;
- (17) Mode of nutritional intake;
 - (a) Combined oral and parenteral or tube feeding;
 - (b) Nasogastric tube feeding;
 - (c) Abdominal feeding tube;
 - (d) Parenteral feeding; or
- (18) Other treatment(s) that may require management through a nursing facility or hospitalization, evaluated through clinical review by the Department;
- (ii) Defined medical conditions:
 - (1) Epilepsy;
 - (2) Conditions or diseases which make cognitive, activity of daily living, mood, or behavior patterns unstable including fluctuating, precarious, or deteriorating;
 - (3) End-stage disease, six or fewer months to live;
 - (4) Severe pressure ulcer;
 - (5) Deep craters in the skin;
 - (6) Breaks in skin exposing muscle or bone;
 - (7) Spinal cord dysfunction;
 - (8) Comatose or persistent vegetative state;
 - (9) Cerebral palsy;
 - (10) Macro or microcephaly;
 - (11) Muscular dystrophies;
 - (12) Seizure disorder;
 - (13) Traumatic brain injury;
 - (14) Congenital heart disorder;
 - (15) Cystic fibrosis;
 - (16) Cancer;
 - (17) Explicit terminal prognosis;
 - (18) Failure to thrive;
 - (19) Renal failure; or
 - (20) A fluctuating, inconsistent medical condition that has required the child to receive hospitalization related to a single medical condition:
 - (a) One or more times in the past 90 days; or
 - (b) For at least 30 days, if the child is less than 12 months old; or
- (iii) A condition which a licensed medical provider has documented as terminal or a persistent condition in which the absence of active treatment would result in hospitalization.

003.01(A)(ii)(1)(b) ADDITIONAL CRITERIA FOR MEDICAL CONDITIONS AND TREATMENTS. In addition to having a medical condition or treatment

identified above, the present medical condition or treatment must:

- (1) Impact the child's functioning or independence on a daily basis; and
- (2) Require 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.

003.01(A)(ii)(1)(b)(i) 48 MONTHS THROUGH 17 YEARS. For children ages 48 months through 17 years, documentation of the daily effect of a defined medical condition or treatment on the child's functioning or independence is required.

003.01(B) ACTIVITIES OF DAILY LIVING (ADL) FOR CHILDREN AGE 48 MONTHS THROUGH 17 YEARS. Information about limitations in activities of daily living (ADL) is obtained from observation of the child in the home setting, reports from parents, guardians or caregivers, current medical records, school records, and standardized assessments. Activities in daily living (ADL) are considered a limitation when the child, due to their physical disabilities, requires physical assistance from another person on a daily basis, or supervision, monitoring, or direction to complete the age appropriate tasks associated with each activity of daily living (ADL) defined in this section. For the purposes of this section, the term "ability" must be interpreted to include the physical ability, cognitive ability, age appropriateness, 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;
- (2) Dressing;
- (3) Personal Hygiene;
- (4) Eating;
- (5) Mobility;
- (6) Toileting; and
- (7) Transferring.

003.01(B)(i) OTHER CONSIDERATIONS FOR CHILDREN AGE 48 MONTHS THROUGH 17 YEARS. The below are the considerations for use with 003.01(A)(2)(c) of this chapter.

- (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 make themselves understood. This includes expressing information content, both verbal and nonverbal; and
- (4) Behavior: The child requires interventions based on a documented behavior management program developed and monitored by a psychiatrist.

psychologist, mental health practitioner, or school counselor.

003.02 PERSONS ELIGIBLE. To be eligible for a level of care (LOC) determination, a person must:

- (1) The person must be determined to be eligible for Medicaid, or under consideration for Medicaid eligibility;
 - (a) The person must be requesting Medicaid funding to cover nursing facility (NF) services or Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities.

003.02(A) SPECIAL CIRCUMSTANCES NOT EVALUATED OR SCREENED. Level of care (LOC) will not be evaluated or reevaluated for Medicaid clients who:

- (i) 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;
- (ii) Are Medicaid-eligible clients who admit to the nursing facility (NF) under hospice care;
- (iii) Are nursing facility (NF) residents who elect hospice upon becoming Medicaid eligible;
- (iv) 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;
- (v) Direct transfer from one nursing facility (NF) to another nursing facility (NF);
- (vi) Are currently, or were previously eligible the month prior to nursing facility (NF) admission, for the Aged and Disabled Waiver program through the Department;
- (vii) Are admitted to a special needs nursing facility (NF) unit; or
- (viii) Are seeking out-of-state nursing facility (NF) admission.

003.02(B) EVALUATION FORMAT. Evaluations will be conducted using common evaluation tools. The evaluation tools reflect each area of nursing facility level of care (NF LOC) criteria, the amount of assistance required, and the complexity of the care.

003.02(C) REFERRAL.

003.02(C)(i) 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.

003.02(C)(ii) RECEIVING REFERRALS. When the Department or its agent 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, the Department determines whether the applicant meets nursing facility level of care (NF LOC).

003.02(C)(iii) APPLICABLE TIME FRAMES. A referral will only be accepted if it is verified by the Department that an application has been received and is under consideration or if an individual is determined eligible for Medicaid. The Department must complete a level of care (LOC) evaluation within 48 hours. If the evaluation is not completed by the Department within 48 hours, the applicant for admission must be deemed by the Department to be appropriate for admission until a level of care (LOC) determination is completed and any required notice is given.

003.02(C)(iii)(1) 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 the Department when information is received that Medicaid has been approved. If the following conditions are met, Medicaid coverage will be retroactive to the date of Medicaid eligibility:

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

003.02(C)(iii)(2) 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.

003.02(C)(iii)(3) REFERRAL AFTER DEATH OR DISCHARGE. A level of care (LOC) referral will also be accepted and a medical records-based level of care (LOC) determination 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.

003.02(C)(iii)(4) DETERMINATION OTHERWISE REQUIRED. A level of care (LOC) determination will be required in all other cases for nursing facility (NF) admission.

003.02(D) OUTCOMES OF THE EVALUATION.

003.02(D)(i) NURSING FACILITY LEVEL OF CARE (NF LOC) MET. If the Department determines that the applicant meets nursing facility level of care (NF LOC) and the client chooses to receive nursing facility (NF) services, the Department will make appropriate notifications.

003.02(D)(ii) NURSING FACILITY LEVEL OF CARE (NF LOC) NOT MET. If the Department determines that the applicant does not meet nursing facility level of care (NF LOC), notification of the determination is issued to the applicant, the facility, and the managed care organization. Persons who are found to be ineligible for Medicaid reimbursement for nursing facility (NF) service will be sent a notice of denial by the Department.

003.02(D)(iii) 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 Department may indicate that short-term or time-limited nursing facility (NF) care is medically necessary. Prior to the end of the short-term or time-limited stay, the nursing facility (NF) must contact Medicaid to review the client's condition and determine future nursing facility level of care (NF LOC).

003.02(E) NOTICES AND APPEALS.

003.02(E)(i) LEVEL OF CARE (LOC) DETERMINATION NOTIFICATION. Medicaid staff send notification to each client, family, or 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.

003.02(E)(ii) 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.