NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

September 29, 2021
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

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

The following regulations are proposed for AMENDMENT:

Title 471 NAC 10 – *Hospital Services*

The proposed changes will remove provisions determining the rate methodology that are proposed for inclusion in a new Chapter 46. Additional proposed changes include removing the requirements for the Department to hold a public hearing when making changes to the rate methodology.

Title 471 NAC 12 – *Nursing Facility Regulations*

The proposed changes will remove provisions determining the rate methodology that are proposed for inclusion in a new Chapter 45. Additional proposed changes include removing the requirements for the Department to hold a public hearing when making changes to the rate methodology; and renumbering the regulatory chapter.

The following regulations are proposed for ADOPTION:

Title 471 NAC 45 – *Rates for Nursing Facility Services*

The proposed adoption of this chapter specify the regulations' scope; outline the definitions; set out the rules for all rates and methodology for facility payments, and calculating the actual methodology of nursing facility rates; define the allowable and unallowable costs that the nursing facility may report; establishes the reporting requirements, record retention requirements, audit requirements, penalty requirements, appeal process requirements, and settlement and rate adjustment requirements related to nursing facility rates; set forth the requirements when the holder of a nursing facility provider changes; and define how nursing facility residents are classified.

Title 471 NAC 46 – *Rates for Hospital Services*

The proposed adoption of this chapter specify the regulations' scope; outline the definitions; set out the payment structure for metro acute, other urban acute, and rural acute hospital types; establishes non-payment for hospital acquired conditions, payment for psychiatric services, payment for rehabilitation services, payment for services provided by a critical

access hospital, payment rates for state operated institutions, rates for out of state hospitals, and the rates for out of plan services; set out the rate setting for change in ownership, new operational facility, hospital merger, and depreciation; define lower level of care requirements; specify the requirements for accessing records, audits, provider appeals, and rate adjustments.

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

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 888-820-1398; Participant code: 3213662#.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax or email written comments, 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) 471-8417. Individuals who are deaf or hard of hearing 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.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

TO: Executive Board
Room 2108 State Capitol
Legislative Council

FROM: Marge Respeliers, Paralegal I
Legal Services
Department of Health and Human Services (DHHS)

DATE: August 23, 2021

RE: Notice of Rulemaking under Neb. Rev. Stat. § 84-907.06

The Department of Health and Human Services (DHHS) will be holding a public hearing on amending and adopting the following regulations:

TITLE:	471	Nebraska Medical Assistance Program Services
CHAPTER:	10	Hospital Services
CHAPTER:	12	Nursing Facility Regulations
CHAPTER:	45	Rates for Nursing Facility Services
CHAPTER:	46	Rates for Hospital Services

These regulations are scheduled for public hearing on September 29, 2021.

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

The following regulations are proposed for AMENDMENT:

Title 471 NAC 10 – *Hospital Services*

The proposed changes will remove provisions determining the rate methodology that are proposed for inclusion in a new Chapter 46. Additional proposed changes include removing the requirements for the Department to hold a public hearing when making changes to the rate methodology.

Title 471 NAC 12 – *Nursing Facility Regulations*

The proposed changes will remove provisions determining the rate methodology that are proposed for inclusion in a new Chapter 45. Additional proposed changes include removing the requirements

for the Department to hold a public hearing when making changes to the rate methodology; and renumbering the regulatory chapter.

The following regulations are proposed for ADOPTION:

Title 471 NAC 45 – *Rates for Nursing Facility Services*

The proposed adoption of this chapter specify the regulations' scope; outline the definitions; set out the rules for all rates and methodology for facility payments, and calculating the actual methodology of nursing facility rates; define the allowable and unallowable costs that the nursing facility may report; establishes the reporting requirements, record retention requirements, audit requirements, penalty requirements, appeal process requirements, and settlement and rate adjustment requirements related to nursing facility rates; set forth the requirements when the holder of a nursing facility provider changes; and define how nursing facility residents are classified.

Title 471 NAC 46 – *Rates for Hospital Services*

The proposed adoption of this chapter specify the regulations' scope; outline the definitions; set out the payment structure for metro acute, other urban acute, and rural acute hospital types; establishes non-payment for hospital acquired conditions, payment for psychiatric services, payment for rehabilitation services, payment for services provided by a critical access hospital, payment rates for state operated institutions, rates for out of state hospitals, and the rates for out of plan services; set out the rate setting for change in ownership, new operational facility, hospital merger, and depreciation; define lower level of care requirements; specify the requirements for accessing records, audits, provider appeals, and rate adjustments.

The following items are enclosed for your referral to the chair of the relevant standing committee of the Legislature:

1. A copy of the notice of public hearing;
2. A copy of the proposed regulations;
3. A copy of the Policy Pre-Review Checklist; and
4. The estimated fiscal impact of this rulemaking action on state agencies, political subdivisions or persons being regulated.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 471	Prepared by: Alex Zimmer
Chapter: 10, 12, 45, and 46	Date prepared: 8.5.21
Subject: Hospital Services; Nursing Facility Regulations; Rates for Nursing Facility Services; and Rates for Hospital Services	Telephone: 531.530.7317

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: N/A.

Political Subdivision: N/A.

Regulated Public: N/A.

If indeterminable, explain why:

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 10 HOSPITAL SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

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

002.02 ALL-PATIENT REFINED DIAGNOSIS-RELATED GROUP. The All-Patient Refined Diagnosis-Related Group software application that assigns patients into categories based on severity of illness and risk of mortality.

002.03 BASE YEAR. The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

002.04 CAPITAL-RELATED COSTS. Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

002.05 CASE-MIX INDEX. An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

002.06 COMORBIDITY. The simultaneous presence of two chronic diseases, or conditions, in a patient.

002.07 COORDINATION PLAN. An overall program outline for the delivery of a specific service; it is not an individual patient care plan.

002.08 COST OUTLIER. Cases which have an extraordinarily high cost as established in 471 Nebraska Administrative Code (NAC) 10-004.03 as eligible for additional payments above and beyond the initial diagnosis-related group payment.

002.09 CRITICAL ACCESS HOSPITAL. A hospital licensed as a critical access hospital by the Department of Health and Human Services under 175 NAC 9, and certified for participation by Medicare as a critical access hospital.

002.10 DIAGNOSIS-RELATED GROUP (DRG). A group of similar diagnoses combined based on patient age, birth weight, procedure coding, comorbidity, and complications.

002.11 DIAGNOSIS-RELATED GROUP (DRG) WEIGHT. A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each diagnosis-related group and severity of illness (SOI).

002.12 DIAGNOSTIC SERVICE. An examination or procedure performed either on the patient, or materials obtained from the patient, to provide information for the diagnosis or treatment of a disease or to assess a medical condition. This may include radiological and pathological services.

002.13 DIALYSIS. A process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane.

002.14 DIRECT MEDICAL EDUCATION COST PAYMENT. An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.

002.15 DISPROPORTIONATE SHARE HOSPITAL (DSH). A hospital located in Nebraska is deemed to be a disproportionate share hospital by having either:

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

002.16 DISTINCT PART UNIT. A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

002.17 DURABLE MEDICAL EQUIPMENT. Equipment which withstands repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the client's home.

002.18 EMERGENCY MEDICAL CONDITION. A medical or behavioral condition, the onset of which is sudden, manifesting itself by symptoms of sufficient severity such that the absence of immediate medical attention could result in:

(A) Placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy:
(B) Serious impairment to such person's bodily functions; or
(C) Serious dysfunction of any bodily organ or part; or
(D) With respect to a pregnant woman who is having contractions:
    (i) Inadequate time to effect a safe transfer to another hospital before delivery; or
    (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

002.19 HEALTH CARE-ACQUIRED CONDITIONS. A health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than deep vein thrombosis (DVT) or pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

002.20 HOSPITAL EMERGENCY SERVICES. Services that are necessary to prevent the death of the client or serious impairment of the client's health and, because of the threat to the life or health of the client, necessitate the use of the most accessible hospital equipped to provide the necessary services.

002.21 HOSPITAL INPATIENT SERVICES. Services that:

(A) Are ordinarily furnished in a hospital for the care and treatment of inpatients;
(B) Are furnished under the direction of a physician or dentist;
(C) Are furnished in an institution that:
  (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
  (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;
  (iii) Meets the requirements for participation in Medicare as a hospital; and
  (iv) 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, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services; and
(D) Do not include special needs facilities (SNF) and independent clinical laboratory (ICF) services furnished by a hospital with a swing-bed approval.

002.22 HOSPITAL MERGERS. Hospitals that have combined into a single entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

002.23 HOSPITAL OUTPATIENT OBSERVATION SERVICES. Observation services are those services furnished by a hospital on the hospital premises, including use of a bed and periodic monitoring by a hospital’s nursing staff or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Some patients may require a second day of outpatient observation services. A maximum of 48 hours of observation may be reimbursed. When a client receives hospital observation services and is thereafter admitted as an inpatient of the same hospital, the hospital observation services are included in the hospital's payment for the inpatient services.

002.24 HOSPITAL OUTPATIENT SERVICES. Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients under the direction of a physician, optometrist, ophthalmologist, audiologist or dentist in an institution that meets provider requirements.

002.25 HOSPITAL-AFFILIATED AMBULATORY SURGICAL CENTER (HAASC). An ambulatory surgical center operated by a hospital. A hospital-affiliated ambulatory surgical center (HAASC) may be covered under Medicare, and therefore under Nebraska Medicaid,

as an ambulatory surgical center (ASC) or a hospital-affiliated ambulatory surgical center (HAASC).

002.26 HOSPITAL-ACQUIRED CONDITION (HAC). A condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission.

002.27 HOSPITAL-SPECIFIC BASE YEAR OPERATING COST. Hospital-specific operating allowable cost associated with treating Nebraska Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

002.28 HOSPITAL-SPECIFIC COST-TO-CHARGE RATIO. Hospital-specific cost-to-charge ratio is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-specific cost-to-charge ratios used for outlier cost payments and transplant diagnosis-related group cost-to-charge ratio (CCR) payments are derived from the outlier cost-to-charge ratios (CCR) in the Medicare inpatient prospective payment system.

002.29 INDEPENDENT CLINICAL LABORATORY (ICF). A laboratory which is operated by or under the supervision of a hospital or the organized medical staff of the hospital which does not meet the definition of a hospital is considered to be an independent laboratory. However, a laboratory serving hospital inpatients and outpatients and operated on the premises of a hospital which meets the definition of a hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not classified as an independent clinical laboratory. The hospital's certification covers the services performed in this laboratory.

002.30 INDIRECT MEDICAL EDUCATION COST PAYMENT. Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education cost payments.

002.31 INFANT OR INFANCY. The time period from an individual’s birth through completion of one year of age.

002.32 INPATIENT. A patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who:

(A) Receives room, board and professional services in the institution for a 24 hour period or longer; or

(B) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

002.33 INPATIENT DAYS. The number of days of care covered for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Nebraska Medicaid reporting purposes, even if the hospital uses a different definition of a day for statistical or other purposes. The day of admission is counted as a full day.

002.33(A) PART OF DAY. Except for the day of admission, a part of a day, including the day of discharge, death, or a day on which a patient begins a leave of absence, is not counted as a day. Charges for ancillary services on the day of discharge or death, or the day on which a patient begins a leave of absence are covered. If inpatient admission and discharge or death occur on the same day, the day is considered a day of admission and counted as one inpatient day.

002.33(B) ANCILLARY AREAS. When a registered inpatient is occupying any other ancillary area, such as surgery or radiology, at the census-taking hour before occupying an inpatient bed, the patient must be included in the inpatient census of the routine care area, not the ancillary area.

002.33(C) MEDICARE METHODOLOGY. The Department utilizes the current Medicare methodology in accounting for the inpatient accommodations on the Nebraska Medicare cost report.

002.34 LOW-INCOME UTILIZATION RATE. For the cost reporting period ending in the calendar year preceding the Nebraska Medicaid rate period, the sum, expressed as a percentage, of the fractions, calculated from acceptable data submitted by the hospital as follows:

(A) Total Nebraska Medicaid inpatient revenues, excluding those payments for disproportionate share hospitals, paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services, including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals in the same cost reporting period; and

(B) The total amount of the hospital's charges for hospital inpatient services attributable to uncompensated care in ending in the calendar year preceding the Nebraska Medicaid rate period, less the amount of any cash subsidies identified in item (A) of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to uncompensated care does not include contractual allowances and discounts, other than for uncompensated care for patients not eligible for Nebraska Medicaid, that is, reductions in charges given to other third-party payors.

002.35 MEDICAID ALLOWABLE INPATIENT CHARGES. Total claim submitted charges less claim non-allowable amount.

002.36 MEDICAID ALLOWABLE INPATIENT DAYS. The total number of covered Medicaid inpatient days.

002.37 MEDICAID INPATIENT UTILIZATION RATE. The ratio of one allowable Medicaid inpatient days, as determined by Nebraska Medicaid, two total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out-of-state Nebraska Medicaid patients for the same time

period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Nebraska Medicaid rate period.

002.38 MEDICAID RATE PERIOD. The period of July 1 through the following June 30.

002.39 MEDICAL NECESSITY. Health care services and supplies which are medically appropriate and:

(A) Necessary to meet the basic health needs of the client;
(B) Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
(C) Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
(D) Consistent with the diagnosis of the condition;
(E) Required for means other than convenience of the client or his or her physician;
(F) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
(G) Of demonstrated value; and
(H) No more intense level of service than can be safely provided.

002.40 MEDICAL REVIEW. Review of Nebraska Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay, completeness, adequacy, and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

002.41 MEDICAL SOCIAL SERVICES. Medical social services are those social services which contribute meaningfully to the treatment of a patient's condition. These services include, but are not limited to:

(A) Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the hospital;
(B) Appropriate action to obtain case work services to assist in resolving problems in these areas; and
(C) Assessment of the patient's medical and nursing requirements, his or her home situation, his or her financial resources, and the community resources available to him or her in making the decision regarding their discharge.

002.42 MEDICAL SUPPLIES. Expendable or specified reusable supplies required for care of a medical condition and used in the client's home must be prescribed by a physician or other licensed practitioner within the scope of their licensure. This includes dressings, colostomy supplies, catheters, and other similar items.

002.43 MEDICARE COST REPORT. The report filed by each facility with its Medicare intermediary. The Medicare cost report is available through the National Technical Information Service.

002.44 NEONATAL INTENSIVE CARE. Intensive care services provided to an infant in an intensive care unit specially equipped to care for infants.

002.45 NEW OPERATIONAL FACILITY. A facility providing inpatient hospital care which meets one of the following criteria:

(A) A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;

(B) A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or

(C) A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.

002.46 NON-PATIENT. An individual receiving services who is neither an inpatient nor an outpatient. When a sample or specimen is obtained by personnel not employed by the hospital and is sent to the hospital for tests, the tests are non-patient services because the patient is not registered as an inpatient or an outpatient of the hospital. If the sample is obtained by hospital personnel, the tests are outpatient services.

002.47 NURSERY CARE. Services for a newborn child from time of birth to time of discharge of the mother from the facility.

002.48 OPERATING COST PAYMENT AMOUNT. The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

002.49 OTHER PROVIDER-PREVENTABLE CONDITIONS (OPPC). A wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

002.50 ORTHOTICS. Rigid or semi-rigid devices to prevent or correct physical deformity or malfunction, to support a weak or deformed part of the body, or to eliminate motion in a diseased or injured part of the body.

002.51 OUTPATIENT. A person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services.

002.52 PASS OR LEAVE OF ABSENCE. A patient is absent from the hospital, but has not been discharged from the facility. A hospital may place a patient on a leave of absence when readmission is expected, and the patient does not require a hospital level of care during the interim period.

002.53 PATHOLOGICAL SERVICES. Microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or other pathological examinations or procedures performed on materials obtained from the patient to provide information for the diagnosis or treatment of a disease or an assessment of the medical condition of the patient.

002.54 PRESENT ON ADMISSION (POA) INDICATOR. A status code the hospital uses on an inpatient claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs.

002.55 PROSTHETIC. A device which replaces a missing part of the body.

002.56 PROVIDER-PREVENTABLE CONDITIONS (PPC). An umbrella term which is defined as two distinct categories: health care-acquired conditions (HCAC) and other provider-preventable conditions (OPPC).

002.57 RADIOLOGICAL SERVICES. Services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic purposes and associated medical services necessary for the diagnosis and treatment of the patient.

002.58 REPORTING PERIOD. Same reporting period as that used for its Medicare cost report.

002.59 RESOURCE INTENSITY. The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

002.60 RISK OF MORTALITY (ROM). The likelihood of dying.

002.61 SEVERE OBESITY. Body Mass Index greater than 35.

002.62 SEVERITY OF ILLNESS LEVEL (SOI). The extent of physiologic decompensation or organ system loss of function.

002.63 CLINICAL TRIALS. For services not subject to Food and Drug Administration (FDA) approval, the following definitions apply:

(A) Phase I: Initial introduction of an investigational service into humans.

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

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

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

002.65 THERAPEUTIC SERVICES. Services and supplies which are not diagnostic services, are furnished incident to the services of physicians and practitioners, and which aid physicians and practitioners in the treatment of patients.

002.66 UNCOMPENSATED CARE. Uncompensated care includes the difference between costs incurred and payments received in providing services to Nebraska Medicaid patients and uninsured.

002.67 WARD. Either:

(A) A large room in the hospital for the accommodation of several patients; or

(B) A division within a hospital for the care of numerous patients having the same condition.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, hospital providers must comply with all the applicable participation requirements. In the event that provider participation requirements in 471 NAC 2 or 3 conflict with the requirements outlined in this 471 NAC 10, the individual provider participation requirements in 471 NAC 10 will govern.

003.02 SPECIFIC PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, a hospital that provides hospital inpatient or outpatient or emergency room services must:

(i) Be maintained primarily for the care and treatment of patients with disorders other than mental disease;

(ii) Be licensed as a hospital by the Department or the officially designated authority for state standard-setting in the state where the hospital is located;

(iii) Have licensed and certified hospital beds; and

(iv) Meet the requirements for participation in Medicare and Medicaid.

003.02(A) PROVIDER AGREEMENT. To participate in Nebraska Medicaid, a hospital must complete Form MC-20: "Medical Assistance Hospital Provider Agreement," and submit the completed form to the Department. A copy of Form CMS-1539: Medicare/Medicaid Certification and Transmittal, must be submitted as part of the enrollment process.

003.02(B) INDEPENDENT CLINICAL LABORATORY. An independent clinical laboratory must be independent both of an attending or consulting physician's office, and of a hospital. A clinical laboratory must meet the following criteria:

(i) When state or applicable local law provides for licensing of independent clinical laboratories, the laboratory must be licensed under the law; and

(ii) The laboratory must also meet the health and safety requirements prescribed by the U.S. Secretary of Health and Human Services.

003.02(C) PROVIDERS OF PORTABLE X-RAY SERVICES. To be approved as a Nebraska Medicaid provider, providers of portable x-ray services must be certified by the Centers for Medicare and Medicaid Services (CMS) Regional Office. Each provider must submit a copy of Form CMS-1539: Medicare/Medicaid Certification and Transmittal, and

remain in compliance with 42 CFR 486.100 through 486.110. An out-of-state portable x-ray provider must provide the Department with verification of certification from the Centers for Medicare and Medicaid Services Regional Office. The Department approves or denies enrollment as a Nebraska Medicaid provider based on the certification information received from the Centers for Medicare and Medicaid Services Regional Office.

003.02(C)(i) APPLICABILITY OF HEALTH AND SAFETY STANDARDS. Health and safety standards outlined in 180 NAC will apply to all providers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services. Payment is made only for services of approved providers who have been found to meet the standards.

003.02(D) DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES. The Department does not generally approve hospitals as providers of durable medical equipment and medical supplies. Exception: Apnea monitors and home phototherapy equipment.

003.02(E) APPROVAL AS AN AMBULATORY ROOM AND BOARD PROVIDER. The Department approves only hospitals as ambulatory room and board providers. To be eligible to receive Nebraska Medicaid payment for ambulatory room and board services, each hospital providing those services must be enrolled with the Department as a provider for hospital services and must submit Form MS-6: Ambulatory Room and Board Agreement. The Department may request additional information from the hospital to approve ambulatory room and board services.

003.02(E)(i) PROVIDER RE-APPROVAL. Each hospital approved by the Department to provide ambulatory room and board services must seek re-approval of its ambulatory room and board services from the Department when any of the following occur:

(1) The charge to the Department for ambulatory room and board services changes;
(2) There is a change in the physical location of the ambulatory room and board facility or the distance from the hospital building;
(3) There is a change in the services the hospital is able to provide to clients in the ambulatory room and board facility; or
(4) Other substantial changes are made to the hospital's ambulatory room and board services.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

004.01(A) MEDICAL NECESSITY. Services and supplies that do not meet the definition of medical necessity are not covered. The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Nebraska Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered. Approval by the Food and Drug Administration or similar

approval does not guarantee coverage by the Department. Licensure or certification of a particular provider type does not guarantee Nebraska Medicaid coverage.

004.01(B) PRIOR AUTHORIZATION. The Department requires that physicians request prior authorization from the Department before providing:

(1) Medical transplants;
(2) Abortions;
(3) Cosmetic and reconstructive surgery;
(4) Bariatric surgery for obesity;
(5) Out-of-State Services. Exception: Prior authorization is not required for emergency services;
(6) Established procedures of questionable current usefulness;
(7) Procedures which tend to be redundant when performed in combination with other procedures;
(8) New procedures of unproven value;
(9) Certain drug products;
(10) Sleep study for a child under the age of six years old; and
(11) Ventricular Assist Device.

004.01(B)(i) PRIOR AUTHORIZATION PROCEDURES. The physician must request prior authorization for these services in writing, or by using the standard electronic Health Care Services Review.

004.01(B)(i)(1) REQUEST FOR ADDITIONAL EVALUATIONS. The Department may request, and the provider must submit, additional evaluations when the Department determines that the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

004.01(B)(i)(2) PRIOR AUTHORIZATION APPROVAL/DENIAL PROCESS. The prior authorization request review and determination must be completed by one or all of the following Department representatives:

(a) Medical Director;
(b) Designated Department Program Specialists; and
(c) Medicaid Medical Consultants or Contractors for certain specialties.

004.01(B)(i)(3) NOTIFICATION PROCESS. Upon determination of approval or denial, the Department provides a written response to the following, as applicable, and depending on the source of the request:

(a) Physician(s) submitting or contributing to the request;
(b) Caseworker; and
(c) Medical Review Organization when appropriate.

004.01(B)(ii) VERBAL AUTHORIZATION PROCEDURES. The Department may issue a verbal authorization when circumstances are of an emergency nature, or urgent to the extent that a delay would place the client at risk of not receiving medical

care. When a verbal authorization is granted, a written request or electronic request using the standard electronic Health Care Services Review – Request for Review and Response transaction must be submitted within 14 days of the verbal authorization. A written or electronic response from the Department will be issued upon completion of the review.

004.01(B)(iii) BILLING AND PAYMENT REQUIREMENTS. Claims submitted to the Department for services requiring prior authorization will not be paid without written or electronic approval. A copy of the approval letter or notification of authorization issued by the Department must be submitted with all claims related to the procedure or service authorized.

004.02 SPECIFIC REQUIREMENTS.

004.02(A) SERVICES PROVIDED FOR CLIENTS ENROLLED IN NEBRASKA MEDICAID. Certain Nebraska Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program (Managed Care). Managed Care plans are required to provide, at a minimum, coverage of services as described in this chapter. Services provided to clients enrolled in a managed care plan are not billed to the Department. The provider must provide services only under arrangement with the managed care organization (MCO). The prior authorization requirements, payment limitations, and billing instructions outlined in this chapter do not apply to services provided to clients enrolled in a managed care plan with the following exceptions:

(i) Medical Transplants: Transplants continue to require prior authorization by the Department and are reimbursed on a fee-for-service basis, outside the managed care organization's (MCO) capitation payment;
(ii) Abortions: Abortions require prior authorization by the Department and are included in the capitation fee for the managed care organization (MCO); and
(iii) Family Planning Services: The client must be able to obtain family planning services upon request and from any appropriate provider who is enrolled in Nebraska Medicaid. Family planning services are reimbursed by the managed care organization (MCO), regardless of whether the service is provided by a primary care provider (PCP) enrolled with the managed care organization (MCO) or a family planning provider outside the managed care organization (MCO).

004.02(B) PRIOR AUTHORIZATION FOR TRANSPLANT SERVICES. The Department requires prior authorization of all transplant services. Physicians must request prior authorization before performing any transplant service or related donor service.

004.02(B)(i) Prior authorization requests must include at a minimum:

(1) The patient's name, Medicaid ID, and date of birth;
(2) Diagnosis, pertinent past medical history and treatment, prognosis with and without the transplant, and the procedure(s) for which the authorization is requested;
(3) Name of the hospital, city, and state where the service(s) will be performed, including the National Provider Identification number of the provider. All providers must be enrolled with Medicaid before services are performed. Out-of-state services are covered in accordance with 471 NAC 1;

(4) Name of the physician(s) who will perform the surgery if other than the physician requesting authorization; and

(5) In addition to the above information, a physician specializing in the specific transplantation must also supply the following:

(a) The screening criteria used in determining that a patient is an appropriate candidate for the requested transplant;

(b) The results of that screening for this patient (i.e., the patient is eligible to be placed on a "waiting list" for solid organ transplantation in which the only remaining criteria is organ availability); and

(c) A written statement by the physician:

(i) Recommending the transplant;

(ii) Certifying and explaining why the transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the client's life in a meaningful, qualitative way and at a reasonable level of functioning; and

(iii) Psycho-social evaluation for solid organ transplants. Exception: For heart and liver transplants, a second physician specializing in the specific transplant must also supply a second written statement meeting the above criteria.

004.02(C) PRIOR AUTHORIZATION FOR GASTRIC BYPASS SURGERY. Prior authorization request must include, but is not limited to, documentation of:

(i) Medical diagnoses;

(ii) Body mass index 35 or greater with one of the following co-morbidities:

(1) Diabetes Mellitus (include recent lab results and current medications);

(2) Hypertension (include current medications, including antihypertensive and blood pressure readings);

(3) Coronary Artery Disease, Congestive Heart Failure, or dyslipidemia (include recent lab results and current medications);

(4) Obstructive sleep apnea (include sleep study results and treatment);

(5) Gastroesophageal Reflux Disease (include test results and current medications being used to manage the symptoms);

(6) Osteoarthritis (include information about the client’s ability to ambulate, assistive devices used and any medications being used to manage symptoms);

(7) Pseudo tumor cerebri (include diagnostic reports/imaging); or

(8) Cardiac and pulmonary evaluations if existing cardio-pulmonary co-morbidities (provide all related consults).

(iii) Dietary consultation, including documentation showing completion of a supervised diet program for six months or more, and a determination that the patient is motivated to comply with dietary changes;

(iv) Psychiatry or psychology consultation that includes:

(1) Evaluation to determine readiness for surgery and lifestyle change; and

(2) No behavior health disorder by history and physical exam:

(a) Exam includes no severe psychosis or personal disorder; and

(b) Mood or anxiety disorder excluded and treatment (if treated, include treatment medications or modalities).

(v) Drug or alcohol screen:

(1) No drugs or alcohol by history, or alcohol and drug free for a period of one year or greater; and
(2) No history of smoking, or smoking cessation has been attempted.

(vi) Patients understanding of surgical risk, post procedure compliance and follow-up.

004.03 COVERED INPATIENT SERVICES.

004.03(A) BED AND BOARD. The Department pays the same amount for inpatient services whether the client has a private room, a semiprivate room, or ward accommodations.

004.03(B) PASSES OR LEAVES OF ABSENCE. The day on which a client begins a pass or leave of absence may be treated as a day of discharge. Therapeutic passes will be evaluated for medical necessity and are subject to medical review or the Department's utilization review (UR) activities. The hospital is not paid for therapeutic passes or leave days.

004.03(C) NURSING SERVICES. Nursing and other related services and use of hospital facilities for the care and treatment of inpatients are included in the hospital's payment for inpatient services.

004.03(D) SERVICES OF INTERNS AND RESIDENTS-IN-TRAINING. The Department covers the reasonable cost of the services of interns or residents-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

004.03(D)(i) APPROVED PROGRAMS FOR PODIATRIC INTERNS AND RESIDENTS-IN-TRAINING. The services of interns and residents-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association are covered under Nebraska Medicaid on the same basis as the services of other interns and residents-in-training in approved teaching programs.

004.03(D)(ii) DENTAL INTERNS AND RESIDENTS-IN-TRAINING. For services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must be approved by the Council of Dental Education of the American Dental Association.

004.03(E) OUTPATIENT/EMERGENCY SERVICES. When a client receives hospital outpatient or emergency room services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the hospital outpatient or emergency room services are covered by the Department as inpatient services. Hospital outpatient services furnished in the outpatient or emergency room to a patient classified as "dead on arrival" are covered through pronouncement of death, providing the hospital considers these patients as outpatients for recordkeeping purposes and follows its usual outpatient billing

practices for services to all patients. This coverage does not apply if the patient was pronounced dead before arrival at the hospital.

004.03(F) ANCILLARY SERVICES. Payment for the ancillary services described in this section is included in the payment for inpatient services. Outpatient services must be claimed using the appropriate national standard code sets.

004.03(G) BLOOD ADMINISTRATION. For clients who are receiving both Medicare and Medicaid benefits, the Department covers the first three pints of blood. Autologous blood donation processing costs are not covered for reimbursement by the Department. The Department covers any blood administration not covered by Medicare or other third-party insurance if it is medically necessary. Hospitals must distinguish between blood and blood processing costs under the following rules:

(i) Blood Costs: A hospital's blood costs will consist of amounts it spends to procure blood, including:
  (1) The cost of activities as soliciting and paying donors and drawing blood for its own blood bank; and
  (2) When a hospital purchases blood from an outside blood source an amount equal to the amount of credit which the outside blood source customarily gives the hospital if the blood is replaced.

(ii) Blood Processing: A hospital's blood processing costs consist of amounts spent to process and administer blood after it has been procured, including:
  (1) The cost of such activities as storing, typing, cross-matching, and transfusing blood;
  (2) The cost of spoiled or defective blood. This cost does not include blood that is spoiled or defective as a result of general storage expiration; and
  (3) The portion of the outside blood source's blood fee which remains after credit is given for replacement.

004.03(H) PERSONAL CARE ITEMS. The Department covers personal care items, such as lotion, toothpaste, and admit kits, when they are necessary for the care of a client during inpatient or outpatient services.

004.04 DRUGS.

004.04(A) INPATIENT DRUGS. The Department covers drugs for use in the hospital which are ordinarily provided by the hospital for the care and treatment of inpatients. Payment for inpatient drugs is included in the hospital's payment for inpatient services.

004.04(B) HOSPITAL OUTPATIENT OR EMERGENCY ROOM DRUGS. The Department covers drugs utilized in the actual treatment as part of the outpatient or emergency room service. The hospital must bill drugs used in the outpatient or emergency room service by National Drug Code (NDC) on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). Providers must also report the quantity and unit of measure of the National Drug Code (NDC). Include the correct National Drug Code (NDC) information on all claims, including Medicare and other third party claims.

004.05 MEDICAL SUPPLIES AND EQUIPMENT.

004.05(A) INPATIENT SUPPLIES AND EQUIPMENT. The Department covers supplies and equipment provided to inpatients for use during the inpatient stay. These are included in the hospital's payment for inpatient services. Certain items used during the client's inpatient stay are included in the hospital's payment for inpatient services even though they leave the hospital with the client. This includes items used in the actual treatment of the patient which are permanently or temporarily inserted in or attached to the patient's body.

004.05(B) HOSPITAL OUTPATIENT AND EMERGENCY ROOM SUPPLIES AND EQUIPMENT. The Department covers medically necessary supplies and equipment used for outpatient and emergency room services. This includes items used in the actual treatment of the patient as well as items necessary to facilitate the patient's discharge.

004.05(C) TAKE-HOME SUPPLIES AND EQUIPMENT. The Department covers the following supplies and equipment:

(1) Up to a 10-day supply of take-home supplies following an inpatient or outpatient service. Durable medical equipment must be billed by appropriate provider with the exception of rental apnea monitors and home phototherapy units.

004.05(C)(i) INFANT APNEA MONITORS. The Department covers rental of home infant apnea monitors for infants with medical conditions that require monitoring due to a specific medical diagnosis only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent or caregiver training must occur before placement of infant apnea monitor. Payment for hospital apnea monitoring services provided to an inpatient is included in the hospital payment for inpatient services.

004.05(C)(ii) PHOTOTHERAPY SERVICES. The Department covers phototherapy equipment on a rental basis for infants that meet the following criteria:

(a) Neonatal hyperbilirubinemia is the infant's sole clinical problem;
(b) The infant is greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gm (5 lbs.);
(c) The infant is greater than 48 hours of age;
(d) Bilirubin level at initiation of phototherapy (greater than 48 hours of age) is 14-18 mgs per deciliter. Home phototherapy is not covered if the bilirubin level is less than 12 mgs at 72 hours of age or older; and
(e) Direct bilirubin level is less than 2 mgs per deciliter.

004.06 LABORATORY AND PATHOLOGY.

004.06(A) PROFESSIONAL COMPONENT. The Department covers as a physician's service the professional component of laboratory services provided by a physician to an individual patient in accordance with the provisions of 471 NAC 18. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

004.06(B) CLINICAL LAB SERVICES. Clinical laboratory services are considered technical components and must be billed as such. The Department covers the technical component of clinical laboratory services provided to hospital inpatients, outpatients, and non-patients performed by non-physicians manually or using automated laboratory equipment. Payment is made to the hospital as follows:

(1) Inpatient Services: Payment is included in the hospital's payment for inpatient services. The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate.

(2) Outpatient Services: Payment is made at the fee schedule determined by Centers for Medicare and Medicaid Services. Outpatient clinical laboratory services must be itemized on the appropriate claim form or electronic format using the appropriate healthcare common procedure coding system procedure codes.

(3) Non-Patient Services: Payment is made at the fee schedule determined by Centers for Medicare and Medicaid Services.

004.06(B)(i) LEASED DEPARTMENTS. Leased department status has no bearing on billing or payment for clinical lab services. The hospital must claim all clinical lab services, whether performed in a leased or non-leased department. Payment for the total service (professional and technical component) is made to the hospital. The Department does not make separate payment for the professional component for clinical lab services.

004.06(C) ANATOMICAL PATHOLOGY SERVICES. Services which ordinarily require a physician's interpretation. If these services are provided to hospital inpatients or outpatients, the professional and technical components must be separately identified for billing and payment. There is no separate payment made to the pathologist for routine clinical lab services. To be paid, the pathologist must negotiate with the hospital to arrange a salary or compensation agreement.

004.06(C)(i) BILLING AND PAYMENT FOR HOSPITAL INPATIENT ANATOMICAL PATHOLOGY SERVICES. Payment for the technical component of anatomical pathology is included in the hospital's payment for inpatient services which is claimed on the appropriate claim form or electronic format as an ancillary service. The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate. The pathologist must claim the professional component of anatomical pathology on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate healthcare common procedure system procedure code and a "26" modifier. This service is paid according to the Nebraska Medicaid Practitioner Fee Schedule.

004.06(C)(i)(1) EXCEPTION. If an anatomical pathology specimen is obtained from a hospital inpatient but is referred to an independent laboratory or the pathologist of a second hospital's laboratory, the independent lab or the pathologist of the second hospital's laboratory to which the specimen has been referred may claim payment for the total service on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

004.06(C)(ii) BILLING AND PAYMENT FOR HOSPITAL OUTPATIENT ANATOMICAL PATHOLOGY SERVICES. The hospital must bill the technical component of outpatient anatomical pathology services in a summary bill format using the appropriate revenue code on the appropriate claim form or electronic format. The pathologist must claim the professional component on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate healthcare common procedure system procedure code and a "26" modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

004.06(C)(ii)(1) EXCEPTION. If an anatomical pathology specimen is obtained from a hospital outpatient and is referred to an independent lab or the pathologist of a second hospital's laboratory, the independent lab or the pathologist of a second hospital's laboratory to which the specimen was referred may claim payment for the total service on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

004.06(C)(iii) BILLING AND PAYMENT FOR NON-PATIENT ANATOMICAL PATHOLOGY SERVICES. For specimens from non-patients referred to the hospital, the hospital must bill the total service on the appropriate claim form or electronic format using the appropriate revenue code.

004.06(C)(iv) LEASED DEPARTMENTS. If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist must claim the total service (professional and technical components) on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule. Leased department status has no bearing on billing for or payment for hospital inpatient or outpatient anatomical pathology services.

004.06(D) ADJUSTMENT BASED ON LEGISLATIVE APPROPRIATIONS. The starting point for the payment amounts must be adjusted by a percentage. This percentage will be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

004.07 HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES. Hospital diagnostic and therapeutic services are procedures performed to determine the nature and severity of an illness or injury, or procedures used to treat disease or disorders. Hospital diagnostic and therapeutic services include both hospital inpatient and outpatient services. Hospital diagnostic and therapeutic services are comprised of two distinct elements: the professional component and the technical component.

004.07(A) PROFESSIONAL COMPONENT. See 471 NAC 18.

004.07(B) TECHNICAL COMPONENT. The technical component of hospital diagnostic and therapeutic services is comprised of two distinct elements:

(1) Physicians' professional services not directly related to the medical care of the individual patient; and
(2) Hospital services.

004.07(B)(i) Payment for the technical component of inpatient services is included in the hospital's payment for inpatient services whether provided directly or under arrangement with an outside provider. The hospital is responsible for payment of all services provided to an inpatient under arrangement by an outside provider, except ambulance services, to the outside provider (for inpatient services) if the service is provided under arrangement.

004.07(B)(ii) The technical component of outpatient and non-patient services must be claimed by the provider actually providing the service. The Department's payment for the technical component includes payment for all non-physician services required to provide the procedure; including, but not limited to stat fees, specimen handling, call back, room charges, etc.

004.07(D) NON-PHYSICIAN SERVICES AND ITEMS. All non-physician services, drugs, medical supplies, and items, provided to hospital inpatients or outpatients must be provided directly by the hospital or under arrangements. If the services or items are provided under arrangements, the hospital is responsible for payment to the non-physician provider or supplier. The Department prohibits the "unbundling" of costs by hospitals for non-physician services or supplies provided to hospital patients, including ancillary services provided by another hospital.

004.08 RADIOLOGY. The Department covers medically necessary radiological services provided to inpatients and outpatients. The Department covers only those services which are directly related to the patient's diagnosis and the provider must indicate the diagnosis which reflects the condition for which the service is performed on the claim from, and if necessary, include a notation on the claim which documents the need. A radiological laboratory is not considered an independent laboratory under Medicaid. All radiology services have a technical component and a professional component (physician interpretation). The professional and technical component of hospital services must be separately identified for billing and payment.

004.08(A) PROFESSIONAL COMPONENT. The professional component of radiology services provided by a physician to an individual patient is covered in accordance with 471 NAC 10.

004.08(B) TECHNICAL COMPONENT. The Department covers the technical component of hospital radiology services, such as administrative or supervisory services or services needed to produce the x-ray films or other items that are interpreted by the radiologist.

004.08(C) COMPUTERIZED TOMOGRAPHY (CT) SCANS. The Department covers diagnostic examinations of the head and of certain other parts of the body performed by computerized tomography (CT) scanners when:
(i) Medical and scientific literature and opinion support the use of a scan for the condition;
(ii) The scan is reasonable and necessary for the individual patient; and

(iii) The scan is performed on a model of computerized tomography (CT) equipment that meets Medicare's criteria for coverage.

004.08(D) MAMMOGRAMS. The Department covers diagnostic and screening mammograms. Mammography services are covered only for providers who have met Medicare certification criteria for mammography services.

(i) Screening mammography: Screening mammograms are a preventive radiology procedure performed for early detection of breast cancer. The Department covers one screening mammogram annually according to the periodicity schedule and guidelines of the American Cancer Society.

(ii) Diagnostic mammography: Diagnostic mammograms are covered based on the medical necessity of the service.

004.08(E) PORTABLE X-RAY SERVICES. The Department covers diagnostic x-ray services provided by a certified portable x-ray provider when provided in a place of residence used as the patient's home and in nonparticipating institutions. These services must be performed under the general supervision of a physician and certain conditions relating to health and safety must be met.

004.08(E)(i) COVERED PORTABLE X-RAY SERVICES. The Department covers the following portable x-ray services:

(1) Skeletal films involving arms and legs, pelvis, vertebral column, and skull;

(2) Chest films which do not involve the use of contrast media; and

(3) Abdominal films which do not involve the use of contrast media.

004.08(E)(ii) SPECIAL NEEDS FACILITIES. The Department covers diagnostic portable x-ray services when provided in participating special need facilities, under circumstances in which they cannot be covered as special need facilities services. If portable x-ray services are provided in a participating hospital under arrangement, the hospital must bill the Department for the service.

004.08(E)(iii) ELECTROCARDIOGRAMS. The taking of an electrocardiogram tracing by an approved supplier of portable x-ray services can be covered as an "other diagnostic test." The health and safety standards in 471 NAC 10 must be met.

004.08(E)(iv) CERTIFIED PROVIDERS. Providers of portable x-ray services must be certified by the Centers for Medicare and Medicaid Services Regional Office. The Centers for Medicare and Medicaid Services Regional Office updates certification information and sends the information to the Department according to the federal time frame which is currently in effect for portable x-ray providers.

004.08(E)(iv)(1) NEBRASKA PORTABLE X-RAY PROVIDER. The provider must submit Form CMS-1539: Medicare/Medicaid Certification and Transmittal.

004.08(E)(iv)(2) OUT-OF-STATE PORTABLE X-RAY PROVIDER. The Department approves or denies enrollment based on verification of certification information received from the Centers for Medicare and Medicaid Services Regional Office.

004.08(E)(v) APPLICABILITY OF HEALTH AND SAFETY STANDARDS. The health and safety standards apply to all providers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services. Payment is made only for services of approved providers who have been found to meet the standards.

004.08(E)(v)(1) When the services of a provider of portable x-ray services no longer meet the conditions of coverage, physicians responsible for supervising the portable x-ray services and having an interest in the x-ray provider's certification status must be notified. The notification action regarding suppliers of portable x-ray equipment is the same as required for decertification of independent laboratories, and the same procedures are followed.

004.08(F) RADIOLOGY FOR ANNUAL PHYSICAL EXAMS FOR CLIENTS RESIDING IN NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). The Department requires that all long term care facility residents have an annual physical examination. The physician, based on their authority to prescribe continued treatment, determines the extent of the examination for Nebraska Medicaid clients based on medical necessity.

004.08(G) BILLING AND PAYMENT FOR RADIOLOGY SERVICES.

004.08(G)(i) BILLING AND PAYMENT FOR HOSPITAL INPATIENT RADIOLOGY SERVICES. Payment for the technical component of inpatient radiology services is included in the hospital's payment for inpatient services. These costs may be included on the hospital's cost report to be considered in calculating the hospital's payment rate. Physicians must claim the professional component of inpatient radiology services on Form CMS-1500 or the standard electronic Healthcare Common Procedure Coding System Claim: Professional transaction (ASC X12N 837) using the appropriate healthcare procedure code with a "26" modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

004.08(G)(ii) BILLING AND PAYMENT FOR HOSPITAL OUTPATIENT RADIOLOGY SERVICES. The hospital must claim the technical component of outpatient radiology services on the appropriate claim form or electronic format. Payment is made according to 471 NAC 10. The physician must claim the professional component on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate Healthcare Common Procedure Coding System procedure code with a "26" modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

004.08(G)(iii) BILLING AND PAYMENT FOR NON-PATIENT RADIOLOGY SERVICES. A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. If a radiology procedure is performed for a non-patient, the hospital must claim the total component on the appropriate claim form or electronic format.

004.08(G)(iv) LEASED DEPARTMENTS. If the radiology department is leased and the service is provided to a non-patient, the radiologist must claim the total service - both technical and professional components - on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

004.09 OUTPATIENT DIAGNOSTIC SERVICES PROVIDED BY ARRANGEMENT. The Department covers medically necessary diagnostic services provided to an outpatient by arrangement.

004.09(A) SPECIMEN COLLECTION FEES. Separate charges made by laboratories for drawing or collecting specimens are allowable whether or not the specimens are referred to another hospital or laboratory for testing. This fee will be paid to the provider who extracted the specimen from the patient. Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test, the series is treated as a single encounter. A specimen collection fee is allowed for activities such as drawing a blood sample through venipuncture or collecting a urine sample by catheterization.

004.09(A)(i) A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from a patient who resides in a nursing facility or who is homebound. The technician must personally draw the specimen. A specimen collection fee is not allowed for a visiting technician when a patient in a facility is not confined to the facility or when the facility has personnel on duty qualified to perform the specimen collection.

004.09(A)(ii) The fees allowed for a visiting technician cover the travel expenses of the technician, as well as the specimen drawing service, and the material and supplies used. Exceptions to this rule may be made when it is clear that the payment is inequitable in light of the distances the technician must travel to perform the test for nursing home or homebound patients in rural areas.

004.09(A)(iii) A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal, such as a throat culture, a routine capillary puncture, or a pap smear.

004.10 AMBULANCE SERVICES. A hospital-based ambulance service is an ambulance service owned and operated by a hospital. Providers of ambulance services must meet the licensure and certification requirements of the Nebraska Department of Health, Division of Public Health, Regulation and Licensure Unit. Providers of hospital-based ambulance services must comply with all applicable requirements. In addition to the medical necessity requirements outlined in 471 NAC 10, hospital-based ambulance service must comply with 471 NAC 4. In the event that the requirements in 471 NAC 4 conflict with requirements outlined in 471 NAC 10, the individual requirements in this chapter will govern.

004.10(A) BILLING FOR HOSPITAL-BASED AMBULANCE SERVICES. Hospital-based ambulance services provided to an inpatient or an outpatient must be claimed on the appropriate claim format or electronic format as a hospital outpatient service by the

hospital-based ambulance provider. Hospital-based ambulance services are reimbursed as a hospital outpatient service. Hospital-based ambulance costs are not included in the calculations for hospital inpatient rates.

004.10(B) GROUND AMBULANCE SERVICES.

004.10(B)(i) BASIC LIFE SUPPORT (BLS) AMBULANCE. A basic life support (BLS) ambulance provides transportation plus the equipment and staff needed for basic services such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, cardio-pulmonary resuscitation (CPR), defibrillation, etc.

004.10(B)(ii) ADVANCED LIFE SUPPORT (ALS) SERVICES. An advanced life support (ALS) ambulance provides transportation and has complex specialized life-sustaining equipment and, ordinarily, equipment for radio-telephone contact with a physician or hospital. An advanced life support (ALS) ambulance is appropriately equipped and staffed by personnel trained and authorized to provide specialized services such as administering IVs (intravenous therapy), establishing and maintaining a patient's airway, defibrillating the heart, relieving pneumothorax conditions, and performing other advanced life support procedures or services such as cardiac (EKG) monitoring.

004.10(B)(iii) BASE RATES. Ground ambulance base rates include all services, equipment and other costs, including: vehicle operating expenses, services of two attendants and other personnel, overhead charges, reusable and disposable items and supplies, oxygen, pharmaceuticals, unloaded and in-town mileage, and usual waiting or standby time.

004.10(C) MILEAGE. Loaded mileage- miles traveled while the client is present in the ambulance vehicle - is covered for out-of-town ambulance transports. Out-of-town transports are defined as trips in which the final destination of the client is outside the limits of the town in which the trip originated. "Unloaded" mileage is included in the payment for the base rate.

004.10(D) THIRD ATTENDANT. A third attendant is covered only if the circumstances of the transport requires three attendants. The circumstances which required the third attendant must be documented on or with the claim when billing the Department. Payment for a third attendant cannot be made when the third attendant is:

(i) Needed because a crew member is not qualified to provide a service; or
(ii) Staff provided by the hospital to accompany a client during transport.

004.10(E) WAITING OR STANDBY TIME. Waiting or standby time is separately reimbursed only when unusual circumstances exist. The unusual circumstances including why the ambulance waited and where the wait took place must be documented on or with the claim when billing the Department. When waiting time is covered, the first one-half hour is not reimbursed. Payment for waiting time under normal circumstances is included in the payment for the base rate.

004.10(F) AIR AMBULANCE. The Department covers medically necessary air ambulance services only when transportation by ground ambulance is contraindicated and:

(1) Great distances or other obstacles are involved in getting the client to the destination;
(2) Immediate and rapid admission is essential; or
(3) The point of pickup is inaccessible by land vehicle.

004.10(F)(i) When billing the Department, the provider must bill air ambulance services as a single charge which includes base rate and mileage. The number of "loaded" miles must be included on the claim. If a determination is made that ambulance transport is medically necessary, but ground ambulance would have been appropriate, payment for the air ambulance service is limited to the amount allowable for ground transport.

004.10(G) LIMITATIONS AND REQUIREMENTS FOR CERTAIN AMBULANCE SERVICES.

004.10(G)(i) EMERGENCY AND NON-EMERGENCY TRANSPORTS. Emergency transports are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(a) Placing the client's health in serious jeopardy;
(b) Serious impairment to bodily functions; or
(c) Serious dysfunction of any bodily organ or part.

004.10(G)(i)(1) Any ambulance transport that does not meet the definition of an emergency transport must be billed as a non-emergency transport. This includes all scheduled runs regardless of origin and destination and transports to nursing facilities or to the client's residence.

004.10(G)(ii) TRANSPORTS TO THE FACILITY WHICH MEETS THE NEEDS OF THE CLIENT. Ambulance services are covered to enable the client to obtain medical care in a facility or from a physician or practitioner that most appropriately meets the needs of the client, including:

(1) Support from the client's community or family; or
(2) Care from the client's own physician, practitioner, or a qualified physician or practitioner or specialist.

004.10(G)(iii) TRANSPORTS TO A PHYSICIAN/PRACTITIONER'S OFFICE, CLINIC OR THERAPY CENTER. Emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered. Non-emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered when:

(1) The client is bed confined before, during, and after transport; and
(2) The services cannot or cannot reasonably be expected to be provided at the client's residence including a nursing facility or intermediate care facilities for individuals with developmental disabilities (ICF/DD).

004.10(G)(iv) ROUND TRIP TRANSPORTS FOR HOSPITAL INPATIENTS. Ambulance services provided to a client receiving hospital inpatient services, where the client is transported to another facility for services and the client is returned to the originating hospital for continuation of inpatient care, are not included in the payment to the hospital for inpatient services and must be billed by the hospital-based ambulance provider.

004.10(G)(v) COMBINED ADVANCED LIFE SUPPORT (ALS)/ BASIC LIFE SUPPORT (BLS) TRANSPORTS. When a client is transferred from a basic life support (BLS) vehicle to an advanced life support (ALS) ambulance, the advanced life support (ALS) service may be billed, however only one ambulance provider may submit the claim for the service.

004.10(G)(v)(1) When the placement of advanced life support (ALS) personnel and equipment on board a basic life support (BLS) vehicle qualifies the basic life support (BLS) vehicle as an advanced life support (ALS) ambulance, the advanced life support (ALS) service may be billed.

004.10(G)(vi) TRANSPORT OF MORE THAN ONE CLIENT. When more than one client is transported during a single trip, a base rate is covered for each client transported. The number of loaded miles and mileage charges must be prorated among the number of clients being billed. A notation that the mileage is prorated and why must be on or with the claim when billing the Department.

004.10(G)(vii) TRANSPORT OF MEDICAL TEAMS. Transport of a medical team or other medical professionals to meet a client is not separately reimbursed. If the transport of the medical team results in an ambulance transport of the client, the services are included in the base rate of the client's transport.

004.10(G)(viii) TRANSPORT OF DECEASED CLIENTS. Ambulance services are covered if the client is pronounced dead while en route to or upon arrival at the hospital. Ambulance services are not covered if a client is pronounced dead before the client is transported.

004.11 PRE-ADMISSION TESTING. The Department covers pre-admission testing and diagnostic services rendered up to three days before the day of admission, as an ancillary.

004.11(A) The Department does not cover pre-admission testing performed in a physician's office or as an outpatient which is performed solely to meet hospital pre-admission requirements.

004.12 HOSPITAL ADMISSION DIAGNOSTIC PROCEDURES. In addition to meeting medical necessity requirements, the major factors which are considered to determine that a diagnostic procedure performed as part of the admitting procedure to a hospital is reasonable and medically necessary are:

(A) The test is specifically ordered by the admitting physician, or a hospital staff physician responsible for the patient when there is no admitting physician (i.e., the test is not provided on the standing orders of a physician for all their patients);

(B) The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and
(C) The test does not unnecessarily duplicate:
(i) The same test performed on an outpatient basis before admission; or,
(ii) The same test performed in connection with a separate, but recent, hospital admission.

004.13 THERAPEUTIC SERVICES. Therapeutic services, including physical, respiratory, occupational, speech, or psychological therapies which a hospital provides to an inpatient or outpatient are those services which are incidental to the services of the physicians in the treatment of patients. Covered therapeutic services to hospital inpatients or outpatients include the services of therapists and equipment necessary for therapeutic services.

004.13(A) COVERED SERVICES – PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES. The Department covers physical therapy, occupational therapy, speech pathology, and audiology services in accordance with the criteria outlined in 471 NAC 17, 471 NAC 14, and 471 NAC 23 respectively.

004.13(B) RESPIRATORY THERAPY. The Department covers respiratory therapy when provided by a respiratory therapist or technician in accordance with the conditions and criteria outlined in 471 NAC 22.

004.14 ANESTHESIOLOGY.

004.14(A) PROFESSIONAL COMPONENT. The Department covers the professional component of anesthesiology services provided by a physician to an individual patient in accordance with 471 NAC 18. Rural hospitals that have been exempted by their Medicare fiscal intermediary for certified registered nurse anesthetist (CRNA) billing must follow the Medicare billing requirements.

004.14(A)(i) MEDICAL DIRECTION OF FOUR OR FEWER CONCURRENT PROCEDURES. The Department covers the professional component for the physician's personal medical direction of concurrent anesthesiology services provided by qualified anesthetists, such as certified registered nurse anesthetists (CRNA), in accordance with 471 NAC 10. The professional component of personal services up to and including induction is covered as a physician's service and must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

004.14(B) TECHNICAL COMPONENT. If the physician leaves the immediate area of the operating suite for longer than short durations, devotes extensive time to an emergency case, or is otherwise not available to respond to the immediate needs of surgical patients, the physician's services to the surgical patient are supervisory in nature and are considered a technical component.

004.14(B)(i) MEDICAL DIRECTION OF MORE THAN FOUR CONCURRENT PROCEDURES. If the physician is involved in providing direction for more than four concurrent procedures or is performing other services while directing the concurrent

procedures, the concurrent anesthesia services are covered as the technical component of the hospital services. The physician must ensure that a qualified individual performs any procedure in which the physician does not personally participate.

004.14(C) STANDBY ANESTHESIA SERVICES. A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs and ready to furnish anesthesia services to a specific patient who is known to be in potential need of services. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

004.14(D) NURSE ANESTHETIST. The hospital may engage the services of a nurse anesthetist, either on a salary or fee-for-service basis, under arrangements which provide for billing to be made by the hospital. Reimbursement for the service when provided to an inpatient or outpatient is included in the payment rate under Nebraska Medicaid.

004.15 OUTPATIENT SURGICAL PROCEDURE. When a patient with a known diagnosis enters a hospital for a specific surgical procedure or other treatment that is expected to keep the individual in the hospital for less than 24 hours, and this expectation is realized, the patient will be considered an outpatient regardless of the hour of admission; whether or not the patient used a bed; and whether or not the patient remained in the hospital past midnight. If the patient receives 24 or more hours of care, the patient is considered an inpatient regardless of the hour of admission or whether the patient remained in the hospital past midnight or the census-taking hour.

004.16 OUTPATIENT OBSERVATION SERVICES. The Department covers a maximum of 48 hours of outpatient observation. After 48 hours, the patient must either be admitted as an inpatient, by written order, or discharged.

004.17 HOSPITAL DENTAL SERVICES. When dental treatment is necessary as a hospital inpatient or outpatient service, these services must be provided, billed and reimbursed in accordance with the provisions of 471 NAC 6.

004.18 OTHER ANCILLARY SERVICES.

004.18(A) EMERGENCY ROOM PHYSICIANS' SERVICES. The hospital must bill the Department for emergency room physicians' services on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the physician's provider number.

004.18(B) DIALYSIS SERVICES. The Department covers both hemodialysis and peritoneal dialysis as acceptable modes for treatment of end stage renal disease.

004.18(B)(i) INPATIENT DIALYSIS SERVICES. Dialysis services provided to an individual who is an inpatient are considered to be inpatient services.

004.18(B)(ii) OUTPATIENT DIALYSIS SERVICES. Outpatient dialysis services are those dialysis services provided to an individual who is an outpatient. Outpatient dialysis services must be provided by a Medicare certified renal dialysis facility.

004.18(B)(iii) PAYMENT FOR OUTPATIENT DIALYSIS SERVICES. Outpatient dialysis services are reimbursed at the provider's current Medicare composite rate for the services provided. Payment excludes the cost of physician services.

005. NON-COVERED SERVICES. The following services are not intended to be an all-inclusive, or exhaustive, list of non-covered services.

005.01 SURGICAL PROCEDURES. The Department does not cover:

(A) Acupuncture;
(B) Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
(C) Angiocardiography, utilizing CO_2 method, supervision and interpretation only;
(D) Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
(E) Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
(F) Artificial Heart Transplant;
(G) Ballistocardiogram;
(H) Basal metabolic rate (BMR);
(I) Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
(J) Circumcision, female;
(K) Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
(L) Extra-intra cranial arterial bypass for stroke;
(M) Fabric wrapping of abdominal aneurysm;
(N) Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
(O) Fascia lata by stripper when used as a treatment for lower back pain;
(P) Hypogastric or presacral neurectomy (independent procedure);
(Q) Hysterotomy, non-obstetrical, vaginal;
(R) Icterus index;
(S) Ileal bypass or any other intestinal surgery for the treatment of obesity;
(T) Kidney decapsulation, unilateral and bilateral;
(U) Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;
(V) Ligation of internal mammary arteries, unilateral or bilateral;
(W) Ligation of thyroid arteries (independent procedure);
(X) Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;
(Y) Omentopexy for establishing collateral circulation in portal obstruction;
(Z) Perirenal insufflation;

(AA) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
(BB) Protein bound iodine (PBI);
(CC) Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
(DD) Refractive keratoplasty including keratomileusis, keratophakia, and radial keratotomy;
(EE) Reversal of tubal ligation or vasectomy;
(FF) Sex change procedures;
(GG) Splanchicectomy, unilateral or bilateral, when used as a treatment for hypertension;
(HH) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes or ovaries, one or both;
(II) Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension; and
(JJ) Uterine suspension, with or without presacral sympathectomy.

005.02 OBSOLETE TESTS. Obsolete tests may be covered only if the physician who performs the test justifies the medical necessity for the test. The Department will determine that satisfactory medical necessity exists from the physician's justification. The Department does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:

(A) Amylase, blood isoenzymes, electrophoretic;
(B) Chromium, blood;
(C) Guanase, blood;
(D) Zinc sulphate turbidity, blood;
(E) Skin test, cat scratch fever;
(F) Skin test, lymphopathia venereum;
(G) Circulation time, one test;
(H) Cephalin flocculation;
(I) Congo red, blood;
(J) Hormones, adrenocorticotropin quantitative animal tests;
(K) Hormones, adrenocorticotropin quantitative bioassay;
(L) Thymol turbidity, blood;
(M) Skin test, actinomycosis;
(N) Skin test, brucellosis;
(O) Skin test, leptospirosis;
(P) Skin test, psittacosis;
(Q) Skin test, trichinosis;
(R) Calcium, feces, 24-hour quantitative;
(S) Starch; feces, screening;
(T) Chymotrypsin, duodenal contents;
(U) Gastric analysis pepsin;
(V) Gastric analysis, tubeless;
(W) Calcium saturation clotting time;
(X) Capillary fragility test (Rumpel-Leede);
(Y) Colloidal gold;
(Z) Bendien's test for cancer and tuberculosis;
(AA) Bolen's test for cancer; and

(BB) Rehfuss test for gastric acidity.

005.03 SERVICES REQUIRED TO TREAT COMPLICATIONS OR CONDITIONS RESULTING FROM NON-COVERED SERVICES. The Department may consider payment

for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

005.04 EXPERIMENTAL AND INVESTIGATIONAL SERVICES. The Department does not cover medical services which are considered investigational or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, the Department prohibits payment for these services.

005.04(A) RELATED SERVICES. The Department does not pay for associated or adjunctive services that are directly related to non-covered experimental/investigational services.

005.04(B) COVERAGE REQUESTS FOR NEW SERVICES. Requests for Nebraska Medicaid coverage for new services or those which may be considered experimental or investigational must be submitted to the Department before providing the services, or in the case of true medical emergencies, before submitting a claim. The request for coverage must include sufficient information to document that the new service is not considered investigational or experimental for Nebraska Medicaid payment purposes. Reliable evidence must be submitted identifying the status with regard to the criteria below, cost-benefit data, short and long term outcome data, patient selection criteria that is both disease/condition specific and age specific, information outlining under what circumstances the service is considered the accepted standard of care, and any other information that would be helpful to the Department in deciding coverage issues. Additional information may be requested by the Department.

005.04(C) INVESTIGATIONAL OR EXPERIMENTAL CRITERIA. Services are deemed investigational or experimental by the Medical Director, who may convene ad hoc advisory groups of experts to review requests for coverage. A service is deemed investigational or experimental if it meets any one of the following criteria:

(i) There is no Food and Drug Administration (FDA) or other governmental or regulatory approval given, when appropriate, for general marketing to the public for the proposed use;

(ii) Reliable evidence does not permit a conclusion based on consensus that the service is a generally accepted standard of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease, proposed use, and age group. Also, facility specific data, including short and long term outcomes, must be submitted to the Department;

(iii) The service is available only through an Institutional Review Board (IRB) research protocol for the proposed use or subject to such an Institutional Review Board (IRB) process; or

(iv) The service is the subject of an ongoing clinical trial(s) that meets the definition of a Phase I, Phase II, or Phase III Clinical Trial, regardless of whether the trial is actually subject to Food and Drug Administration oversight and regardless of whether an Institutional Review Board (IRB) process or protocol is required at any one particular institution.

005.05 CUSTODIAL OR RESPITE CARE. The Department does not cover hospital services that are custodial or respite care.

005.06 PRIVATE DUTY NURSING. The services of a private-duty nurse or other private-duty attendant are not covered as a hospital service.

005.07 PROSTHETICS. The Department does not cover external powered prosthetic devices.

005.08 FACILITY BASED PHYSICIAN CLINICS. Physician clinic services provided in a hospital, or a facility under the hospital's licensure, are considered to be a physician's service and are reimbursed accordingly.

005.09 TOBACCO CESSATION SERVICES. Tobacco cessation services are not covered as a hospital service.

005.10 HOSPITAL ACQUIRED CONDITIONS. The Department will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that the Department will, at a minimum, identify as a hospital acquired conditions (HAC), those diagnoses codes that have been identified as Medicare hospital acquired conditions (HAC) when not present on hospital admission.

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

005.12 NON-COVERED PORTABLE X-RAY SERVICES. The Department does not cover the following portable x-ray services:

(A) Procedures involving fluoroscopy;
(B) Procedures involving the use of contrast media;
(C) Procedures requiring the administration of a substance to the patient or injection of a substance into the patient or special manipulation of the patient;
(D) Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
(E) Procedures requiring special technical competency or special equipment or materials;
(F) Routine screening procedures; and

(G) Procedures which are not of a diagnostic nature.

006. LIMITATIONS AND REQUIREMENTS FOR CERTAIN SERVICES.

006.01 PRIOR AUTHORIZATION PROCEDURES. The physician must request prior authorization for these services in writing or the standard electronic Health Care Services

Review: Request for Review and Response transaction (ASC X12N 278) prior to providing the service.

006.01(A) REQUEST FOR ADDITIONAL EVALUATIONS. The Department may request additional evaluations when the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

006.01(B) PRIOR AUTHORIZATION APPROVAL/DENIAL PROCESS. The prior authorization request review and determination must be completed by one or all of the following Department representatives:

(1) Medical Director;
(2) Designated Department Program Specialists; and
(3) Medical Consultants for the Department for certain specialties.

006.01(C) VERBAL AUTHORIZATION PROCEDURES. The Department may issue a verbal authorization when circumstances are of an emergency nature or urgent to the extent that a delay would place the client at risk of receiving medical care. When a verbal authorization is granted, a written request or electronic request using the standard electronic Health Care Services Review: Request for Review and Response transaction (ASC X12N 278) must be submitted within 14 days of the verbal authorization.

006.01(D) BILLING AND PAYMENT REQUIREMENTS. Claims submitted to the Department for services defined as requiring prior authorization will not be paid without written or electronic approval from the Department. A copy of the approval letter or notification of authorization issued by the Department must be submitted with all claims related to the procedure or service authorized.

006.02 HIV TESTING FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME. Payment for HIV testing is limited to medical necessity.

006.02(A) NON-COVERED HIV TESTING. The Department does not pay for HIV testing when there is no history of risk as defined in 471 NAC 10. This includes, but is not limited to, the following:

(i) Routine prenatal screening;
(ii) Routine pre-operative testing;
(iii) Educational or employment requirements;
(iv) Entrance requirements for the armed services; and
(v) Insurance applications.

006.03 MINOR SURGICAL PROCEDURES. Reimbursement for excision of lesions of the skin or subcutaneous tissues includes all services and supplies necessary to provide the

service. The Department does not make additional reimbursement for suture removal to the physician who performed the initial service or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the physician who provided the initial service, the Department may approve separate payment for the suture removal.

006.04 TREATMENT FOR OBESITY. The Department will not make payment for services provided when the sole diagnosis is obesity. While obesity is not itself considered an illness, there are conditions which can be caused by or aggravated by obesity. This may include but is not limited to the following: hypothyroidism, Cushing's disease, hypothalamic lesions, cardiac diseases, respiratory diseases, diabetes, hypertension, diseases of the skeletal system. Treatment for obesity can be covered when the services are an integral and necessary part of a course or treatment.

006.04(A) INTESTINAL BY-PASS SURGERY. The Department does not consider this procedure to be reasonable and necessary, and does not cover the procedure.

006.04(B) GASTRIC BY-PASS SURGERY FOR OBESITY. Gastric by-pass surgery for patients with extreme obesity can be covered when the surgery is:

(a) Medically appropriate for the individual; and
(b) Performed to correct an illness which caused the obesity or was aggravated by the obesity.

006.04(B)(i) This procedure must be performed at a facility that is a Bariatric Surgery Center of Excellence.

006.05 COSMETIC AND RECONSTRUCTIVE SURGERY. The Department covers cosmetic and reconstructive surgical procedures and medical services when medically necessary for the purpose of correcting the following conditions:

(i) Limitations in movement of a body part caused by trauma or congenital conditions;
(ii) Disfiguring or painful scars in areas that are visible;
(iii) Congenital birth anomalies;
(iv) Post-mastectomy breast reconstruction; and
(v) Other procedures determined to be restorative or necessary to correct a medical condition.

006.05(A) EXCEPTIONS. To determine the medical necessity of the condition, the Department requires prior authorization for cosmetic and reconstructive surgical procedures except for the following conditions:

(i) Cleft lip and cleft palate;
(ii) Post-mastectomy breast reconstruction;
(iii) Congenital hemangioma's of the face; and
(iv) Nevus (mole) removals.

006.06 STERILIZATIONS.

006.06(A) COVERAGE RESTRICTIONS. Nebraska Medicaid is prohibited from paying for sterilization of individuals:

(i) Under the age of 21 on the date the client signs Form MMS-100; or

(ii) Legally incapable of consenting to sterilization.

006.06(B) COVERAGE CONDITIONS. The Department covers sterilizations only when:

(i) The sterilization is performed because the client receiving the service made a voluntary request for services;

(ii) The client is advised at the outset and before the request or receipt of their consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized;

(iii) Clients whose primary language is other than English must be provided with the required elements for informed consent in their primary language;

(iv) Suitable arrangements must be made to communicate the required elements of informed consent to an individual who is blind, deaf, or otherwise handicapped.

006.06(C) PROCEDURE FOR OBTAINING SERVICES. Non-therapeutic sterilizations are covered by the Department only when:

(1) Legally effective informed consent is obtained on Form MMS-100: Consent Form from the client on whom the sterilization is to be performed. The surgeon must submit a properly completed and legible Form MMS-100 to the Department before payment of claims can be considered; and

(2) The sterilization is performed at least 30 days following the date informed consent was given. To calculate this time period, day 1 is the first day following the date on which the form is signed by the client. Day 31 in this period is the first day on which the procedure could be covered by the Department. The consent is effective for 180 days from the date Form MMS-100 is signed.

006.06(C)(i) EXCEPTION. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she signed the informed consent for the sterilization. For a premature delivery, the client must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MMS-100.

006.06(C)(ii) INFORMED CONSENT. Informed consent means the voluntary, knowing assent of the client who is to be sterilized after the individual has been given the following information:

(a) A clear explanation of the procedures to be followed;

(b) A description of the attendant discomforts and risks that may follow the procedure, including an explanation of the type and possible effects of an anesthetic to be used;

(c) A description of the benefits to be expected;

(d) Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;

(e) An offer to answer any questions concerning the procedures; and

(f) An instruction that the individual is free to withhold or withdraw their consent to the sterilization at any time before the sterilization without prejudicing their future care and without loss of other project or program benefits to which the client might otherwise be entitled;

(g) Advice that the sterilization will not be performed for at least 30 days, except under the circumstances; and
(h) The individual to be sterilized must be permitted to have a witness of her or his choice present when informed consent was obtained.

006.06(C)(ii)(1) CLIENT RESPONSIBILITY. This information is shown on Form MMS-100, which must be completed by the client.

006.07 HYSTERECTOMIES. For payment of claims for hysterectomies, the surgeon must submit to the Department Form MMS-101: Informed Consent Form, properly signed and dated by the client in which the patient states that they were informed before the surgery was performed that this surgical procedure results in permanent sterility before claims associated with the hysterectomy can be considered. The completed Form MMS101 must be submitted to the Department, by the surgeon before claims for the hysterectomy can be considered for payment. The Department covers a medically necessary hysterectomy if the following conditions have been met:

(i) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and
(ii) The individual or her representative, if any, has signed Form MMS-101 acknowledging receipt of that information.

006.07(A) EXCEPTION. The Department does not require informed consent if:

(1) The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was already sterile before the hysterectomy and states the cause of the sterility.
(2) In the case of a post-menopausal woman, the Department considers the woman to be sterile. All claims related to the procedure must indicate that the client is post-menopausal.
(3) The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the patient determined prior acknowledgment was not possible. The physician must also include certification of the emergency.

006.07(A)(i) A copy of the physician's certification regarding the above exceptions must be submitted to the Department before consideration for payment for claims associated with the hysterectomy can be submitted.

006.07(B) NON-COVERED HYSTERECTOMIES. The Department will not cover a hysterectomy if:

(i) It was performed solely to make the woman sterile; or
(ii) If there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.

006.08 ABORTIONS. The Department covers abortions when the life of the mother would be endangered if the fetus were carried to term for which federal financial participation is currently

available under Title XIX of the Social Security Act and the Nebraska Medicaid State Plan. A physician must certify the diagnosis by medical reports which include the name and address of the client. The treating physician must request and receive prior authorization before providing the service from the Department before providing the service. If approved, the Department will send a letter of authorization to the provider and retains one copy of the letter of authorization. In cases of documented emergencies, authorization may be requested after the service has been provided. All other requirements of this subsection must be met.

006.09 INFERTILITY. The Department limits coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical problem. Reimbursement or coverage is not available when the sole purpose of the service is achieving a pregnancy.

006.10 LABOR AND DELIVERY. The Department covers reasonable and necessary services associated with pregnancy. Medical care for pregnancy is reimbursable, beginning with diagnosis of the condition, continuing through delivery, and ending after the necessary postnatal care, or termination of pregnancy. Postpartum services are covered for a 60-day period beginning on the day the pregnancy ends, and any remaining days in the month in which the 60th day falls, for women who were eligible for, applied for, and received medical assistance on the day the pregnancy ends. After the infant is delivered, the infant is treated as a separate patient for reimbursement purposes.

006.10(A) PHYSICIANS' SERVICES. The Department covers routine prenatal care, delivery, six weeks post-partum care, and routine urinalysis as a package service for physicians in accordance with 471 NAC 18. The Department does not reimburse hospitals for any physicians' services included in the package service.

006.10(B) EXCEPTIONS. The Department may make exceptions to cover hospital outpatient or emergency room services which meet the coverage criteria for medically necessary services which are not included in the physicians' package service.

006.10(C) INPATIENT. If the patient is admitted as an inpatient, and not released the same day, the services are considered inpatient services. If the patient is not admitted as an inpatient, the services are considered outpatient services.

006.11 ALCOHOL AND CHEMICAL DETOXIFICATION. The Department limits payment for alcohol and chemical detoxification to medically necessary treatment, subject to the Department's utilization review. This period includes an average detoxification period of two to three days with an occasional need for up to five days when the patient's condition dictates. A detoxification program for a particular patient may exceed five days and be covered if determined medically necessary by the Department. The Department does not cover services when the detoxification needs of an individual no longer require an inpatient hospital setting.

006.12 OSTEOGENIC STIMULATION. Electrical stimulation to augment bone repair (osteogenic stimulation) can be performed either invasively or non-invasively.

006.12(A) INVASIVE OSTEOGENIC STIMULATION. Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or

by implantation of a coiled cathode wire into the fracture site. For percutaneously-placed cathodes, the power supply is externally placed and the leads connected to the inserted cathodes. For the implanted cathode, the power pack is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. The Department covers use of the invasive device only for non-union of long bone fractures. The Department considers non-union to exist only after six months or more have elapsed without the fracture healing.

006.12(B) NON-INVASIVE OSTEOGENIC STIMULATION. For the non-invasive device, opposing pads wired to an external power supply are placed over the cast. An electromagnetic field is created between the pads at the fracture site. The Department covers use of the non-invasive device only for:

(i) Non-union of long bone fractures;
(ii) Failed fusion; and
(iii) Congenital pseudarthrosis.

006.13 BIOFEEDBACK THERAPY. Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured. Biofeedback therapy differs from electromyography, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. However, an electromyography device may be used to provide feedback with certain types of biofeedback. Biofeedback therapy is covered by the Department only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments have not been successful. This therapy is not covered for treatment of ordinary muscle tension states, for psychosomatic conditions, or for psychiatric conditions.

006.14 DIAGNOSTIC SERVICES. All reasonable and necessary diagnostic tests given for narcolepsy and sleep apnea are covered when the following criteria are met:

(i) The clinic must be affiliated with a hospital;
(ii) Patients must be referred to the sleep disorder clinic by a physician. The clinic must maintain a record of the attending physician's orders with signatures; and
(iii) The need for diagnostic testing must be confirmed by medical evidence, e.g., physician examinations and laboratory tests.

006.14(A) Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered. Most patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over. The overnight stay is considered an integral part of these tests.

006.15 THERAPEUTIC SERVICES. The Department may cover therapeutic services provided they are standard and accepted services, and are reasonable and medically

necessary for the patient. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services will be provided for:

(A) Insomnia that is not associated with psychiatric disorders;
(B) Nocturnal myoclonus;
(C) Sleep apnea;
(D) Drug dependency;
(E) Shift work and schedule disturbances;
(F) Restless leg syndrome;
(G) Hypersomnia;
(H) Somnambulism;
(I) Night terrors or dream anxiety attacks;
(J) Enuresis; and
(K) Bruxism.

006.16 CARDIAC STRESS TESTING AND HOSPITAL OUTPATIENT CARDIAC REHABILITATION PROGRAMS. Stress testing is a covered diagnostic procedure for evaluating chest pain and as a component in the development of rehabilitation exercise prescriptions for the treatment of patients with known cardiac disease provided that during the testing:

(i) A physician is present;
(ii) Emergency equipment is available; and
(iii) A standard emergency procedure plan is in effect.

006.16(A) STRESS TESTING. The use of stress testing in the absence of any specific diagnostic or therapeutic purpose is not covered as reasonable and necessary to the treatment of the patient's condition.

006.16(B) OUTPATIENT. Outpatient cardiac rehabilitation programs consisting of individually prescribed physical exercise or conditioning and concurrent telemetric monitoring. When a program is provided by a hospital to its outpatients, the service is covered as an outpatient service.

006.16(B)(i) CARDIAC REHABILITATION EXERCISE PROGRAM. Hospital outpatient services in connection with a cardiac rehabilitation exercise program are considered reasonable and necessary only during that period of time when the patient's condition is such that the exercises can only be carried out safely under the direct, continuing supervision of a physician, and in a hospital environment. The monitoring required in these programs must be carried out by a hospital-employed nurse trained in cardiac rehabilitation with a physician overseeing the monitoring. Although on occasion physical therapists or occupational therapists are involved in these programs, they generally act only as exercise leaders. These services do not constitute covered physical therapy or occupational therapy. Since the type of cardiac rehabilitation exercise program which can be covered requires a hospital setting, this program is not covered in a skilled nursing facility.

006.16(B)(ii) COVERAGE LIMIT. Coverage is limited to 12 weeks (or 36 sessions) of a monitored exercise program. For coverage beyond a maximum duration of 12 weeks

(or 36 sessions), the provider must submit documentation supporting the patient's need for additional services. Documentation must include:

(1) Progress report and exercise sessions;
(2) Diagnosis;
(3) Cardiac history;
(4) Risk factors;
(5) Other medical problems;
(6) Medications;
(7) Allergies;
(8) Personal habits;
(9) Sources of stress, and support system; and
(10) Treatment plan.

006.17 MEDICAL TRANSPLANTS. The Department covers transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the Department will determine whether the transplant is medically necessary or non-experimental. The Department will cover transplantation services when performed in a facility approved by Centers for Medicaid and Medicare as meeting coverage criteria.

006.17(A) PRIOR AUTHORIZATION. The Department requires prior authorization of all transplant services or related donor service before the services are provided. An exception may be made for emergency situations, in which case verbal approval is obtained by the Department and the notification of authorization is sent later. This request for authorization must be submitted in writing or using the standard electronic Health Care Services Review: Request for Review and Response transaction (ASC X12N 278) by the physician to the Department. The Prior Authorization request must include at a minimum:

(i) The patient's name, age, diagnosis, pertinent past medical history and treatment to this point, prognosis with and without the transplant, and the procedure(s) for which the authorization is requested;
(ii) The patient's Nebraska Medicaid number;
(iii) Name of hospital, city, and state where the service(s) will be performed;
(iv) Name of physician(s) who will perform the surgery, if other than physician requesting authorization; and
(1) If authorization is requested for a liver or heart transplant, in addition to the above information, two physicians must also supply the following statement: Recommending the transplant; and
(2) Certifying and explaining why a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the client's life in a meaningful, qualitative way and at a reasonable level of functioning.

006.17(B) SERVICES FOR A NEBRASKA MEDICAID-ELIGIBLE DONOR. The Department covers medically necessary services, including laboratory tests directly related to the transplant, for the Nebraska Medicaid-eligible donor to a Nebraska Medicaid-eligible client. The services must be directly related to the transplant.

006.17(C) SERVICES FOR A NEBRASKA MEDICAID-INELIGIBLE DONOR. The Department covers medically necessary services, including laboratory tests directly

related to the transplant, for the Nebraska Medicaid-ineligible donor to a Nebraska Medicaid-eligible client. The services must be directly related to the transplant and must directly benefit the Nebraska Medicaid transplant client. Coverage of treatment for complications related to the donor is limited to those that are reasonably medically foreseeable. Claims must be submitted under the Nebraska Medicaid-eligible client's case number.

006.17(D) The Department reserves the right to request any medical documentation from the patient's record to support and substantiate claims submitted for payment.

006.17(E) The Department is the payor of last resort.

006.17(F) HOSPITAL INPATIENT SERVICES. Procurement costs include removal of organ, transportation, and associated costs. These costs must be billed by the transplanting hospital on the appropriate claim form or electronic format and separately identified on the Medicare cost report. The hospital must submit copies of the actual invoices for procurement costs, including transportation costs, on the appropriate claim form or electronic format.

006.17(G) AMBULATORY ROOM AND BOARD. The Department may cover ambulatory room and board services for transplant patients and an attendant if necessary.

006.18 PHYSICIAN SERVICES. Surgeon(s) services will be paid according to the Nebraska Medicaid Practitioner Fee Schedule. This fee will include two weeks' routine post-operative care by the designated primary surgeon. Payment for routine post-operative care will not be made to other members of the surgical team. Physician services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

006.19 ITINERANT PHYSICIAN VISITS. The Department covers non-emergency physician visits provided in a hospital outpatient setting if the services are:

(i) Provided by an out-of-town specialist who has a contractual agreement with the hospital. The Department does not consider general practitioners or family practitioners to be specialists; and
(ii) Determined to have been provided in the most appropriate place of service.

006.19(A) The hospital room charge is considered the technical component of the visit and must be billed on Form CMS-1450 (UB-92).

006.20 INFANT APNEA MONITORS. The Department covers rental of home infant apnea monitors for infants with medical conditions that require monitoring due to a specific medical diagnosis only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent/caregiver training must occur before placement of infant apnea monitor. Parent/caregiver training is not reimbursed as a service separate from infant apnea monitor rental.

006.20(A) MEDICAL GUIDELINES FOR THE PLACEMENT OF HOME INFANT APNEA MONITORS. The Department covers home infant apnea monitoring services for infants,

defined as birth through completion of one year of age, who meet one of the following criteria:

(i) Infants with one or more apparent life-threatening events (ALTE) requiring mouth-to-mouth resuscitation or vigorous stimulation. An apparent life-threatening event (ALTE) is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking, or gagging. In some cases, the observer fears the infant has died;

(ii) Symptomatic preterm infants;

(iii) Siblings of one or more SIDS victims; or

(iv) Infants with certain diseases or conditions, such as central hypoventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants of substance-abusing mothers, or infants with less severe apparent life-threatening events (ALTE).

006.20(B) APPROVAL OF HOME INFANT APNEA MONITOR SERVICE PROVIDERS. The Department covers rental of home infant apnea monitors and related supplies provided only by approved providers. To ensure all home apnea monitoring needs of infants are met, the Department requires the development of a home infant apnea monitor coordination plan. The coordination plan is not an individual patient plan; it is an overall program outline for the delivery of home apnea monitoring services.

006.20(C) DOCUMENTATION REQUIRED AFTER INITIAL RENTAL PERIOD. Monitor rental exceeding the first two-month prescription period requires that an updated physician's narrative report of patient progress and a statement of continued need accompany the claim. A new progress report is required every two months. The report must include:

(i) The number of apnea episodes during the previous prescription period;

(ii) The results of any tests performed during the previous prescription period;

(iii) Additional length of time needed; and

(iv) Any additional information the physician may wish to provide.

006.20(D) REMOVING THE INFANT FROM THE MONITOR. Criteria for removing infants from home infant apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when apparent life-threatening event (ALTE) infants have had two periods, each of three months duration, free of significant alarms or apnea where vigorous stimulation or resuscitation was not needed. Evaluating the infant's ability to tolerate stress during this time is advisable. The provider must state the date of removal of the infant monitor on or in the final claim.

006.20(E) COVERED AND NON-COVERED COMPONENTS. The Department does not cover monitors that do not use rechargeable batteries. The Department does not make separate payment for remote alarms. If provided, payment for a remote alarm is included in the monitor rental. Apnea monitor belts, lead wires, and reusable electrodes are covered for rented apnea monitors.

006.20(F) PNEUMOCARDIOGRAMS. Pneumocardiograms are covered for diagnostic or evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation.

006.20(G) BILLING. The hospital must bill for the technical component of infant apnea monitor services on the appropriate claim form or electronic format. The provider of the apnea monitor must state the date of removal of the infant monitor on the claim.
Physicians' services must be billed as professional services on a CMS-1500 Form or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

006.21 HOME PHOTOTHERAPY. The Department covers rental of home phototherapy (bilirubin) equipment for infants that require phototherapy when neonatal hyperbilirubinemia is the infant's sole clinical problem when prescribed by and used under the supervision of a physician. To ensure that home phototherapy needs of infants are met, the Department requires the development of a coordination plan. The coordination plan is not an individual patient plan; it is an overall program outline for the delivery of home phototherapy services.

006.21(A) APPROVAL OF HOME PHOTOTHERAPY PROVIDERS. The Department covers rental of home phototherapy equipment provided by approved providers. Physicians will not be approved as home phototherapy providers.

006.21(A)(i) The following conditions must be met prior to initiation of home phototherapy:

(a) History and physical assessment by the infant's attending physician has occurred. If home phototherapy begins immediately upon discharge from the hospital, the newborn discharge exam will suffice;
(b) Required laboratory studies have been performed, including, complete blood count (CBC), blood type on mother and infant, direct Coombs, direct and indirect bilirubin;
(c) The physician certifies that the parent or caregiver is capable of administering home phototherapy;
(d) Parent or caregiver have successfully completed training on use of the equipment; and
(e) Equipment must be delivered and set up within 4 hours of discharge from the hospital or notification of provider, whichever is more appropriate. There must be a 24-hour per day repair or replacement service available.

006.21(A)(ii) At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

006.21(B) LIMITATIONS ON COVERAGE OF HOME PHOTOTHERAPY SERVICES. Services will be reimbursed on a daily basis. The Department's daily allowable fee includes:

(i) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
(ii) A minimum of one daily visit to the home by a licensed or certified "health care professional" as identified by the supplier in the "Coordination Plan." The daily visits must include:

(1) A brief home assessment; and
(2) Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available. An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill the Department directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home.

(iii) Complete caregiver training on use of equipment and completion of necessary records.

006.21(C) DISCONTINUING HOME PHOTOTHERAPY. Home phototherapy services will not be covered if the bilirubin level is less than 12 mgs at 72 hours of age or older.

006.21(D) DOCUMENTATION. A physician's narrative report outlining the client's progress and the circumstances necessitating extended therapy must be submitted with the claim when billing for home phototherapy exceeding three days.

006.21(E) PAYMENT. Payment for home phototherapy services does not include physician's professional services or laboratory and radiology services related to home phototherapy. These services must be billed by the physician or laboratory performing the service. The Department daily rental payment includes:

(i) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
(ii) A minimum of one daily visit to the home by a licensed or certified "health care professional" is required. The daily visits must include:
(1) A brief home assessment; and
(2) Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available. An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill Medicaid directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home.
(iii) Complete caregiver training on use of equipment and completion of necessary records.

006.21(F) BILLING REQUIREMENTS. The provider must bill for home phototherapy daily rental on a single claim and indicate the total number of rental days as the units of service using the appropriate claim form or electronic format as outpatient services.

006.22 COORDINATION PLAN REQUIREMENT FOR CERTAIN SERVICES. Providers of apnea monitoring services and phototherapy services must maintain, as a part of the provider’s records, a coordination plan, which must include:

(1) An overview of the services provided, including the provider's charge for the services;
(2) Descriptions and literature on the equipment and all supplies and accessories provided;
(3) Copies of all forms, instructions, and record sheets for client use;

(4) An outline of the training format used to train the client on use of equipment and other training requirements;
(5) The type and frequency of client contact and identification and qualifications of personnel conducting client contacts; and
(6) A statement of the provider's policy on equipment set-up, servicing, and availability for consultation on equipment problems.

006.22(A) The provider must notify the Department of any changes in the coordination plan. After review of the coordination plan, the provider may be required to amend the coordination plan.

006.22(B) APPROPRIATE HOSPITAL SERVICES. Appropriate home infant apnea monitor services provided by a hospital with an approved infant apnea monitor coordination plan includes rental of the apnea monitor, trend event recorder, and ECG/respirator recorder; purchase of related supplies; conversion of cassette recording to tape for interpretation; and CO_2/hypoxia studies.

006.23 AMBULATORY ROOM AND BOARD. The Department covers ambulatory room and board as a related transportation and as follows:

006.23(A) APPROVAL AS AN AMBULATORY ROOM AND BOARD PROVIDER. The Department approves only hospitals as ambulatory room and board providers. To receive the Department payment, each hospital providing ambulatory room and board services must be enrolled with the Department as a provider for hospital services.

006.23(A)(i) PROVIDER RE-APPROVAL. Each hospital approved by the Department to provide ambulatory room and board services must seek re-approval of its ambulatory room and board services from the Department when any of the following occur:

(1) The charge to the Department for ambulatory room and board services changes;
(2) There is a change in the physical location of the ambulatory room and board facility or the distance from the hospital building;
(3) There is a change in the services the hospital is able to provide to clients in the ambulatory room and board facility; or
(4) Other substantial changes are made to the hospital's ambulatory room and board services.

006.23(B) GUIDELINES. The Department covers ambulatory room and board services as follows:

(1) Ambulatory room and board services must be necessary to secure Nebraska Medicaid coverable services, including medical examinations or treatment.
(2) The Department covers meals when receipt of Nebraska Medicaid coverable services requires the client to be away from their home for 12 hours or longer;
(3) The Department covers lodging when an out-of-town overnight stay is necessary while receiving Nebraska Medicaid coverable services or if coverage of ambulatory room and board services will prevent a hospital inpatient stay; and

(4) The Department covers meals and lodging for up to one day before or after receiving services if extensive travel is necessary.
(5) The Department covers up to one person who accompanies the client when the client is physically or mental unable to travel or wait alone. For example, a child's parent or guardian.

006.23(B)(i) Payment for ambulatory room and board services outside these guidelines must be approved by the Department staff.

006.23(C) DOCUMENTATION. The hospital must include a statement that documents the necessity for ambulatory room and board services for a client or for a client and an attendant on the hospital claim.

006.23(D) BILLING AND PAYMENT. The hospital must bill for ambulatory room and board services provided by a Department-enrolled hospital as an outpatient service on the appropriate claim form or electronic format and the appropriate Healthcare Common Procedure Coding System procedure codes. Payment will be made using a hospital-specific rate. Payment to the hospital must not exceed its charge for services provided to the general public.

007. BILLING AND PAYMENT FOR HOSPITAL SERVICES.

007.01 PAYMENT.

007.01(A) GENERAL PAYMENT REQUIREMENTS. The Department will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 10. In the event that individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this 471 NAC 10, the individual payment regulations in 471 NAC 10 must govern.

007.01(B) SPECIFIC PAYMENT REQUIREMENTS.

007.01(B)(i) OUTPATIENT SERVICES. The Department provides reimbursement for hospital outpatient services provided to Nebraska Medicaid eligible clients on a prospective basis in accordance with the rate methodology for Outpatient Hospital and Emergency Room Services. Reimbursement for the following services is included in the prospective rate payment for hospital inpatient services:
(a) Technical Component of Hospital Outpatient Radiology Services;
(b) Non-Patient Radiology Services;
(c) Anesthesiology:
(i) Technical Component of Medical Direction of Four or Fewer Concurrent Procedures for hospital outpatient;
(ii) Technical component of outpatient anesthesiology services provided by anesthetists who are not employees of a physician; and
(d) Medical Transplants, hospital charges for ambulatory stays.

007.01(B)(i)(1) This list is not intended to be an exclusive list of services that are reimbursed as a part of the hospital prospective payment for outpatient services.

Other services that are considered to be included within the scope of services that are reimbursed as a part of the prospective payment for outpatient services include, but are not limited to, the following:

(a) Services which are customarily reimbursed as a part of the prospective payment for outpatient services.

007.01(B)(ii) INPATIENT SERVICES. The Department provides reimbursement for hospital inpatient services provided to Nebraska Medicaid eligible clients on a prospective basis. Each facility, with the exception of critical access hospitals, must receive a prospective rate in accordance with the Department's outlined rate methodology for hospital inpatient services. Reimbursement for the following services is included in the prospective rate payment for hospital inpatient services:

(a) Hospital observation services when the client is thereafter admitted as an inpatient of the same hospital;
(b) Hospital outpatient or emergency room services when the client is thereafter admitted as an inpatient of the same hospital before midnight of the same day;
(c) Non-physician inpatient services and Items:
    (i) Outpatient and emergency room services provided by the hospital before admission; and
    (ii) Outpatient or inpatient services provided by another hospital or free-standing medical facility to an inpatient of the original admitting facility.
    (iii) Payment for durable medical equipment, orthotics, and prosthetics, etc., for hospital inpatients is included in the hospital's payment for inpatient services.
(d) Labor and delivery: The Department utilizes the current Medicare methodology in accounting for labor and delivery charges on the Medicare cost report;
(e) Technical component of inpatient clinical laboratory services: The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate;
(f) Technical component of inpatient anatomical pathology services: The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate;
(g) Technical component of hospital inpatient radiology services: These costs may be included on the hospital's cost report to be considered in calculating the hospital's payment rate;
(h) Anesthesiology:
    (i) Technical component of medical direction of four or fewer concurrent procedures for hospital;
    (ii) Technical component of inpatient anesthesiology services provided by anesthetists who are not employees of a physician;
(i) Inpatient dialysis: The hospital may include the costs of inpatient dialysis services on it cost report to be considered in calculation the hospital payment rate.
(j) Pre-Admission Testing;
(k) Medical transplants:
    (i) Hospital inpatient services, including procurement costs;
    (ii) Technical component of inpatient laboratory and diagnostic and therapeutic radiology;

(l) Infant apnea monitoring services provided to an inpatient.

007.01(B)(ii)(1) This list is not intended to be an exclusive list of services that are reimbursed as a part of the hospital prospective payment for inpatient services. Other services that are considered to be included within the scope of services that are reimbursed as a part of the prospective payment for inpatient services include, but are not limited to, the following:

(a) Services which are included by a hospital in the Medicare cost report; or
(b) Services which are customarily reimbursed as a part of the prospective payment for inpatient services.

007.01(B)(iii) RECONCILIATION TO FACILITY UPPER PAYMENT LIMIT. Facilities will be subject to a preliminary and a final reconciliation of Nebraska Medicaid payments to allowable Nebraska Medicaid costs. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

007.01(B)(iv) TRANSFERS. When a patient is transferred to or from another hospital, the Department will make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

007.01(B)(v) INPATIENT ADMISSION AFTER OUTPATIENT SERVICES. A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. Inpatient services, for billing and payment purposes, includes the following:

(a) Non-physician outpatient services rendered on the day of admission or during the inpatient stay;
(b) Diagnostic services rendered up to three days before the day of admission; and
(c) Admission related non-diagnostic services rendered up to 3 days before the day of admission. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

007.01(B)(v)(1) READMISSIONS. The Department adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All Nebraska Medicaid patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined by medical review.

007.01(B)(vi) INTERIM PAYMENT FOR LONG-STAY PATIENTS. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days. To request an interim payment, the hospital must send the appropriate claim form or electronic format to the Department indicating the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days.

007.01(B)(vi)(1) FINAL PAYMENT FOR LONG-STAY PATIENT. When an interim payment is made for long-stay patients, the hospital must submit a final billing for payment upon discharge of the patient. Upon discharge, payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

007.01(B)(vii) PAYMENT FOR NON-PHYSICIAN ANESTHETIST (CRNA) FEES. Hospitals which meet the Medicare exception for payment of certified registered nurse anesthetist (CRNA) fees as a pass-through by Medicare will be paid for certified registered nurse anesthetist (CRNA) fees in addition to their prospective per discharge payment.

007.01(B)(viii) NON-PAYMENT FOR HOSPITAL ACQUIRED CONDITIONS. The Department will not make payment for those claims which are identified as non-payable by Medicare as a result of avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This provision applies only to those claims in which the Department is a secondary payor to Medicare.

007.01(B)(ix) OUT-OF-PLAN SERVICES. When Managed Care enrollees are provided hospital inpatient services by Nebraska Medicaid enrolled facilities not under contract with the Department's managed care organizations (MCO), the managed care organizations (MCO) are authorized, but are not required, to pay for the care provided at rates the Department would otherwise reimburse providers.

007.01(B)(x) LOWER LEVELS OF CARE. When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. Medically necessary skilled nursing care must be authorized within 15 days of admission.

007.01(B)(x)(1) When a Nebraska Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process (PASP), the Department may pay for the pre-admission screening process (PASP) days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year.

007.01(B)(x)(2) The hospital must request prior authorization from the Department before the pre-admission screening process (PASP) days are provided. The Department will send the authorization to the hospital. Pre-admission screening process (PASP) days will not be considered in computing the hospital's prospective rate.

007.01(C) PAYMENTS FOR PSYCHIATRIC SERVICES. Tiered rates will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier. Payment is made for the day of admission, but not the day of discharge. Mental health and substance abuse services provided to clients enrolled in managed care for the mental health and substance abuse benefits package will be reimbursed by the managed care organization (MCO).

007.01(C)(i) PAYMENT FOR HOSPITAL SPONSORED PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF). The Department reimbursement is capped at the psychiatric residential treatment facilities (PRTF) usual and customary daily charges billed for eligible clients. Public psychiatric residential treatment facilities (PRTF) will be cost-settled annually. Payment rates do not include costs of providing educational, pharmacy and physician services.

007.01(C)(ii) PAYMENT FOR PSYCHIATRIC ADULT INPATIENT SUBACUTE HOSPITAL SERVICES. Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all-inclusive per diem, with the exception of physician services.

007.01(C)(iii) RATES FOR STATE-OPERATED INSTITUTIONS FOR MENTAL DISEASE (IMD). Institutions for mental disease (IMD) operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated institutions will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

007.01(C)(iv) FREE-STANDING PSYCHIATRIC HOSPITALS. When a free-standing psychiatric hospital (in Nebraska or out of state) does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service must bill the Department for the ancillary services provided to inpatients.

007.01(D) PAYMENT FOR SERVICES FURNISHED BY A CRITICAL ACCESS HOSPITAL (CAH). The Department reimburses the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers. Subject to the 96-hour average on inpatient stays in critical access hospitals (CAH), items and services that a critical access hospitals (CAH), provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

007.01(E) DISPROPORTIONATE SHARE HOSPITALS. A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

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

007.01(F) DEPRECIATION. The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

007.01(F)(i) RECAPTURE OF DEPRECIATION. A hospital which is sold for a profit and has received Nebraska Medicaid payments for depreciation must refund to the Department the lower of:
(1) The amount of depreciation allowed and paid by the Department; or
(2) The product of:
(a) The ratio of Nebraska Medicaid allowed inpatient days to total inpatient days; and
(b) The amount of gain on the sale as determined by the Medicare.

007.01(F)(ii) The year(s) for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.

007.01(G) ADJUSTMENT TO RATE. Changes to Nebraska Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital must refund the overpayment amount as determined by the Department to the Department. If the rate adjustment results in increasing a hospital's rate, the Department will reimburse the underpayment amount as determined by the Department to the hospital.

007.01(G)(i) REQUEST FOR RATE ADJUSTMENTS. Hospitals may submit a request to the Department for an adjustment to their rates for the following:
(1) An error in the calculation of the rate;
(2) Extraordinary circumstances. Extraordinary circumstances are limited to:
(a) Changes in routine and ancillary costs, which are limited to:
(i) Intern and resident related medical education costs; and
(ii) Establishment of a subspecialty care unit;
(b) Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase; or

(3) Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:
(a) One-time occurrence;
(b) Less than twelve-month duration;
(c) Could not have been reasonably predicted;
(d) Not of an insurable nature;
(e) Not covered by federal or state disaster relief; and
(f) Not a result of malpractice or negligence.

007.01(G)(ii) ADJUSTMENT CONDITIONS. In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital. If an adjustment is granted, the peer group rates will not be changed. In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital must demonstrate the following:

(1) Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control.
(2) Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.
(3) The rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.

007.07(H) ACCESS TO RECORDS. Hospitals must make all records relating to the care of Nebraska Medicaid patients and any and all other cost information available to the Department, its designated representatives or agents, or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

007.01(H)(i) ADDITIONAL CONDITIONS. Hospitals must allow authorized representatives of the Department, the federal Department of Health and Human Services, and state and federal fraud and abuse units to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department. The hospital must allow the authorized representatives access for the purpose of audit and review at any reasonable time during normal working hours upon written notice by the Department at least one working day before the review and audit.

007.01(J) COST REPORT AUDITS. The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent

public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

007.02(J)(i) NON-PARTICIPATING HOSPITALS. A hospital that does not participate in the Medicare program will complete the Medicare cost report in compliance with Medicare principles and supporting rules, regulations, and statutes. The hospital will file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees. Note: If a nursing facility (NF) is affiliated with the hospital, the nursing facility (NF) cost report must be filed according to 471 NAC 12. Note specifically that the time guidelines for filing nursing facility (NF) cost reports differ from those for hospitals.

007.01(K) PROVIDER APPEALS. A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date according to the procedures in 471 NAC 2. A hospital may also request an adjustment to its rate.

007.01(L) PAYMENT TO HOSPITAL-AFFILIATED AMBULATORY SURGICAL CENTERS (HAASC). The Department pays for services provided in a hospital-affiliated ambulatory surgical center (HAASC) according to 471 NAC 10 unless the hospital-affiliated ambulatory surgical center (HAASC) is a Medicare-participating ambulatory surgical center (ASC). If the hospital-affiliated ambulatory surgical center (HAASC) is a Medicare-participating ambulatory surgical center (ASC), payment is made according to 471 NAC 26.

007.01(M) PAYMENT FOR OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES IN A HOSPITAL. The Department pays for covered outpatient mental health services, except for laboratory services, at the lower of:

(i) The provider's submitted charge; or
(ii) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service.

007.01(N) APPROVAL OF PAYMENT FOR EMERGENCY ROOM SERVICES. At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

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

007.01(N)(i) When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of what would otherwise be allowed. All other Nebraska Medicaid allowable charges incurred in this type of visit will be paid according to 471 NAC 10.

007.01(P) PAYMENT TO A NEW HOSPITAL FOR OUTPATIENT SERVICES. The Department must cost-settle claims for Nebraska Medicaid-covered services which are paid by the Department. The cost settlement will be the lower of costs or charges as reflected on the hospital's cost report. The Department's payment must not exceed the upper limit of the provider's charges for services. Upon the Department's receipt of the hospital's initial Medicare cost report, the Department must no longer consider the hospital to be a "new hospital" for payment of outpatient services.

007.01(Q) PAYMENT TO AN OUT-OF-STATE HOSPITAL FOR OUTPATIENT SERVICES. Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges for all Nebraska hospitals.

007.01(R) ADMINISTRATIVE FINALITY. See 471 NAC 3.

007.01(S) LIMITATIONS ON PAYMENT FOR HOSPITAL SERVICES.

007.01(S)(i) PLACE OF SERVICE. The department may review, reduce, or deny payment for covered outpatient or emergency room drugs, supplies, or services which could have been provided in a less expensive setting.

007.01(S)(ii) ITEMS NOT UTILIZED IN THE FACILITY. Drugs, medical supplies, and services prescribed at discharge from the hospital must be obtained from and billed by the appropriate provider. The Department does not provide payment to a hospital for drugs, supplies, and services prescribed at discharge from the hospital for nursing home residents. Payment for these items is included in the nursing home per diem.

007.01(S)(iii) OUTPATIENT/EMERGENCY SERVICES ON THE SAME DAY AS INPATIENT SERVICES. When a client receives outpatient or emergency room hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the outpatient/emergency room hospital services are treated as inpatient services for billing purposes.

007.01(S)(iv) BILLED CHARGES. Inpatient hospital services are paid on a prospective rate basis, regardless of billed charges.

007.01(T) THE DEPARTMENT'S SURVEILLANCE AND UTILIZATION REVIEW OF HOSPITAL SERVICES. The Department, or its designee, reviews hospital inpatient services for:

(1) Medical necessity, appropriateness of service, and level of care;
(2) Validation of hospital diagnosis and procedure coding information;
(3) Completeness, adequacy and quality of care;
(4) Appropriateness of admission, continued hospitalization, discharge, and transfer; or
(5) Appropriateness of prospective payment outlier cases.

007.01(T)(i) REVIEW ACTIVITIES FOR HOSPITAL INPATIENT SERVICES REIMBURSED ON A PROSPECTIVE PER DISCHARGE BASIS. All hospital inpatient

services reimbursed on a prospective per discharge basis are subject to random retrospective review by the Department or its designee. Admissions within three calendar days of a hospital outpatient service may be included in the sample. In addition to the random sample, focused reviews of inpatient stays for transplant(s) or neonatal intensive care unit (NICU) stays provided in a subspecialty care facility or cost outliers may be done by the Department or its designee.

007.01(T)(i)(1) REVIEW FOR ALL SELECTED CASES. Validation will include:

(a) Validation of diagnostic and procedural information and ICD-9-CM coding;
(b) Medical necessity for inpatient admission and procedure(s);
(c) Stability at discharge; and
(d) Quality of care.

007.01(T)(i)(2) PAYMENT REDUCTION. If the Department, or its designee, determines that either admissions or discharges are performed without medical justification, payment for inpatient services may be denied. Payment can be reduced if coding inaccuracies are identified by the Department or its designee. Any cost outlier which is not determined to be medically necessary for hospital inpatient care by the Department or its designee may qualify for payment as a lower level of care payment.

007.01(T)(ii) REVIEW ACTIVITIES FOR HOSPITAL INPATIENT SERVICES REIMBURSED ON A PROSPECTIVE PER DIEM BASIS. Hospital inpatient care must be reasonable, medically necessary, and appropriate for the class of care being billed. All hospital inpatient admissions must be certified by the Department or its designee prior to payment. Review will include medical necessity, appropriateness of service, and level of care. Payment for services will be denied if the Department or its designee determines the service was not medically necessary. The Department or its designee will conduct these activities through pre-admission, concurrent, and retrospective reviews. If the class of care is not appropriate, the claim may be reduced to the appropriate level of care according to 471 NAC 10 or denied.

007.01(T)(iii) SURVEILLANCE AND UTILIZATION REVIEW OF HOSPITAL OUTPATIENT SERVICES. Claims for payment for hospital outpatient services are subject to review by the Department or its designee. Hospital outpatient care must be reasonable and medically necessary, and must be provided in the most appropriate place of service.

007.02 BILLING.

007.02(A) 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 10, the individual billing requirements in 471 NAC 10 must govern.

007.02(B) SPECIFIC BILLING REQUIREMENTS. Providers of hospital services must submit claims to the Department on Form CMS-1450.

007.02(B)(i) MEDICARE COVERAGE. For a Medicare/Medicaid client, the provider must bill Medicare for appropriate benefits before submitting a claim to the Department except Medicare non-covered services covered by the Department.

007.02(B)(i)(1) MEDICARE PART B. If the Medicare/Medicaid client has exhausted their Medicare Part A benefits, the hospital must bill these services or items to Medicare Part B if the client is covered by Part B before billing the Department. The hospital must enter the amount approved by Medicare as a prior payment on Form CMS-1450 or by electronic format.

007.02(B)(ii) DOCUMENTATION. The Department requires that documentation, when required, be submitted with each claim for hospital services. Documentation must be complete and legible. All Nebraska Medicaid clients sign a release of information statement when they apply for Nebraska Medicaid. If the hospital requires another release, the hospital must obtain that release based on the provider agreement with the Department.

007.02(B)(iii) HOSPITAL-ACQUIRED CONDITIONS (HAC). Effective for inpatient and inpatient crossover claims with a 'From' date of service on or after the effective date of this regulation, hospitals are required to report whether each diagnosis on a Nebraska Medicaid claim was present at the time of patient admission, or present on admission (POA). Claims submitted without the required present on admission (POA) indicators will be denied.

007.02(B)(iii)(1) For claims containing diagnoses that are identified by Medicare as hospital-acquired conditions, other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients and for which the condition was not present on admission (POA), these diagnoses will not be used for All Patient Diagnostic Related Group grouping. The claim will be paid as though any diagnoses included in the list of hospital-acquired conditions (HAC) were not present on the claim. The Department denies payment for any hospital-acquired conditions (HAC) that results in death or serious disability. The Department does not make additional payments for services on inpatient hospital claims that are attributable to hospital-acquired conditions (HAC) and are coded with present on admission (POA) indicator codes "N" or "U". Specifically, for hospitals paid under the:

(i) Diagnostic related group (DRG) payment method, the Department does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).
(ii) Cost to Charges (CCR) payment method, the Department does not pay for charges attributable to the hospital-acquired conditions (HAC).
(iii) Per Diem payment method, the Department will limit provider payment reductions to the extent that the identified PPC would otherwise result in an increase in payment, or if the Department can reasonably isolate for nonpayment the portion of the payment directly related to the PPC.

007.02(B)(iv) OTHER PROVIDER PREVENTABLE CONDITION (OPPC). Effective for inpatient, inpatient crossover, outpatient, and outpatient hospital claims, payment will be denied for the following other provider preventable conditions:

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

007.02(B)(v) NURSERY CARE. Hospitals reimbursed by per diem must bill nursery care unless the newborn:

(1) Is transferred from nursery bassinet care to acute care or intensive care; or
(2) Remains in the hospital after the mother's discharge, if the child is being discharged to the mother's care.

007.02(B)(vi) HOSPITAL UTILIZATION REVIEW (UR). Each hospital must have in effect a utilization review plan that provides for review of services provided by the hospital and by members of the medical staff to Nebraska Medicaid patients.

007.02(B)(vi)(1) COMPOSITION OF THE UTILIZATION REVIEW COMMITTEE. A utilization review (UR) committee consisting of two or more practitioners must carry out the utilization review (UR) function. This commitee must be:

(i) A staff committee of the institution; or
(ii) A group outside the institution established by the local medical society and some or all of the hospitals in the locality or established in a manner approved by the Centers for Medicare and Medicaid Services.

007.02(B)(vi)(1)(a) SMALL INSTITUTION. If, because of the small size of the institution, it is impossible to have a properly functioning staff committee, the utilization review (UR) committee must be established under item two above. The committee's or group's reviews may not be conducted by any individual who has a direct financial interest in that hospital or was professionally involved in the care of the patient whose case is being reviewed. At least two members of the committee must be doctors of medicine or osteopathy. The other members may be:

(i) A doctor of medicine or osteopathy;
(ii) A doctor of dental surgery or dental medicine;
(iii) A doctor of podiatric medicine;
(iv) A doctor of optometry; or
(v) A chiropractor.

007.02(B)(vi)(2) SCOPE AND FREQUENCY OF REVIEWS. The utilization review (UR) plan must provide for review of Nebraska Medicaid patients with respect to the medical necessity of:

(i) Admissions to the hospital;
(ii) The duration of stays; and
(iii) Professional services provided, including drugs.

007.02(B)(vi)(2)(a) REVIEW OF ADMISSIONS. Review of admissions may be performed before, at, or after hospital admission. Except for extended stay reviews, reviews may be conducted on a sample basis.

007.02(B)(vii) DETERMINATIONS REGARDING DENIAL OF MEDICAL NECESSITY OF ADMISSIONS OR CONTINUED STAYS. The determination that an admission or continued stay is not medically necessary:

(a) May be made by one member of the utilization review (UR) committee if the practitioner(s) responsible for the patient's care concur with the determination or fail to present their view when given the opportunity; or
(b) In all other cases, must be made by at least two members of the utilization review (UR) committee.

007.02(B)(vii)(1) MEDICALLY NECESSARY. Before making a determination that an admission or continued stay is not medically necessary, the utilization review (UR) committee must consult the practitioner(s) responsible for the care of the patient, and afford the practitioner(s) the opportunity to present their views. If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given no later than two days after the determination, to the hospital, the patient, and the practitioner(s) responsible for the care of the patient.

007.02(B)(vii)(2) BILLING THE CLIENT. The hospital may bill the client for services provided after the date the client receives notification if the following criteria are met:

(i) The hospital's utilization review (UR) committee has determined that an admission or an extended stay is or was not medically necessary;
(ii) The hospital has met the client notification requirements in 471 NAC 10; and
(iii) The Nebraska Medicaid client chooses to remain in the hospital or be admitted to the hospital.

007.02(B)(vii)(2)(a) PERMISSABLE BILLING. When an individual is admitted to a hospital as a non-Nebraska Medicaid patient and is later determined to be eligible for Nebraska Medicaid, the hospital must not bill the client for services that are covered by the Department. If the services are covered by the Department but have been denied based on medical necessity, the provider must not bill the client. The hospital may bill the client for those services that are specifically not covered by the Department, such as cosmetic surgery.

007.02(B)(vii)(3) EXTENDED STAY REVIEW. The utilization review (UR) committee must make a periodic review as specified in the utilization review (UR) plan of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling or the periodic reviews may be the same for all cases or different for different classes of cases.

007.02(B)(vii)(4) RECERTIFICATION OF CONTINUED STAY. Recertification must be made at least every 60 days after initial certification. Psychiatric inpatient care must be certified every 30 days.

007.02(B)(viii) REVIEW OF PROFESSIONAL SERVICES. The utilization review (UR) committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

007.02(B)(ix) SWING BEDS. The Department covers swing beds only for skilled nursing care where a client requires 24-hour professional nursing care.

007.02(B)(ix)(1) PRIOR AUTHORIZATION. To obtain prior authorization for payment for a client admitted to a swing bed, within 15 days of the date of admission to the swing bed facility staff must:

(a) Complete an admission Form MC-9-NF or use the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);
(b) Submit a copy of Form DM-5 or physician's history and physical;
(c) Complete Long Term Care Evaluation; and
(d) Submit all the information to the local office.

007.02(B)(x) ANCILLARY SERVICES. The hospital must bill for ancillary services for swing-bed patients who are eligible for Nebraska Medicaid only. If Medicare is covering the swing-bed services, the facility must not bill the Department for ancillary services.

007.02(B)(xi) THERAPIES. Laboratory, radiology, respiratory therapy, physical therapy, occupational therapy, and speech pathology and audiology services must be billed on the appropriate claim form or in electronic format as outpatient services. These payments must be reported on the Medicare cost report as outpatient revenues.

008. MEDICAL RECORDS. The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital. For the purposes of 471 NAC 10, the term “medical record” includes electronic health records (EHR).

008.01 ORGANIZATION AND STAFFING. The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

008.01(A) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, including accurate entry of electronic health records (EHR) into computer systems, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

008.01(B) Medical records must be retained in their original or legally reproduced form for a period of five years. The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

008.01(C) The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with federal or state laws, court orders, or subpoenas.

008.02 CONTENT OF RECORD. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. All entries must be legible and complete, and must be signed and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing, or evaluating the service furnished. All records must document the following, as appropriate:

(i) Evidence of a physical examination, including a health history, performed no more than seven days before admissions or within 48 hours after admission;
(ii) Admitting diagnosis;
(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient;
(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;
(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by federal or state law if applicable, to require written patient consent;
(vi) All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs, and other information necessary to monitor the patient's condition;
(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care; and
(viii) Final diagnosis with completion of medical records within 30 days following discharge.

008.02(A) NOTE. All orders must be signed by the ordering physician.

~~009. RATE METHODOLOGY. The department will make the currently utilized rate methodology publicly available.~~

~~009.01 PUBLIC MEETING.~~

~~(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.~~
~~(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.~~

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 habilitative 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 WAIVERED FACILITY. Facilities for which the State Certification Agency has waived professional nurse staffing requirements are classified as waivered if the total number of waivered 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. 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.

006.01 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.

006.02 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.

006.02(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.

006.03 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 indicate 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.

006.04 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.

006.05 IDENTIFICATION CRITERIA.

006.05(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.

006.05(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.

006.05(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.

006.05(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.

006.05(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.

006.06 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.

006.06(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.

006.07 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.

006.07(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.

006.07(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.

006.07(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.

006.08 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.

006.08(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.

006.08(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.

006.08(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.

006.09 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, except for specialized services, which are the responsibility of the State.

006.09(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.

006.09(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.

006.09(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.

006.09(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.

006.09(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.

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

006.09(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.

006.09(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.

006.09(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.

006.09(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.

006.09(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.

006.09(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.

006.10 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.

006.11 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.

006.11(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.

006.11(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.

006.12 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.

006.13 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.

007. NURSING FACILITY (NF) SERVICES.

007.01 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.

007.02 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.

007.03 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.

007.03(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.

007.03(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.

007.03(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.

007.03(D) 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.

007.04 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.

007.05 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.

007.05(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.

007.06 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.

007.06(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.

007.07 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.

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

007.09 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.

007.10 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.

007.11 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).

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

007.13 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).

007.14 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.

007.15 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.

007.16 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 (PASRR) 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.

007.17 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.

007.18 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.

007.19 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.

007.20 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.

007.21 APPEALS OF DISCHARGES, TRANSFERS, AND PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) 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 (PASRR) 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 (PASRR) determination notice. The appeal and hearing must be conducted under 465 NAC 2.

007.22 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.

007.23 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.

007.24 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.

007.25 SPECIFIC PAYMENTS.

007.25(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.

007.25(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.

007.25(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.

007.25(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.

007.25(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 (PASRR):

(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).

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

007.25(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.

007.25(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.

007.25(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.

007.25(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.

007.25(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.

007.25(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.

007.25(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.

007.25(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.

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

008.01 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.

008.02 SPECIALIZED ADD-ON SERVICES.

008.02(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.

008.02(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.

008.02(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.

008.02(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.

008.02(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.

008.02(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.

008.02(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.

008.02(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.

008.02(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.

008.02(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.

008.02(F) PRIOR AUTHORIZATION. For each specialized add-on service a 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 (PASRR) final summary; and
(4) The frequency and duration of the service.

008.02(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.

008.02(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.

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

009.01 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.

009.01(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.

009.01(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.

009.01(B) CLIENTS WITH BRAIN INJURY.

009.01(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.

009.01(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.

009.01(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.

009.01(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:

009.01(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.

009.01(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.

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

009.02 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.

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

009.03(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.

009.03(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.

009.03(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 (IPP) 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.

009.03(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.

009.03(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.

009.03(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.

009.03(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.

009.03(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.

009.03(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.

009.04 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.

009.04(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.

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

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

009.05 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.

009.05(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.

009.06 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.

009.07 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.

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

009.08 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 (PASRR) 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 (PASRR) regulations in this chapter. These individuals need more support than nursing facilities would normally provide, but not at a “specialized services” level.

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

009.08(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.

009.08(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.

009.08(D) CRITERIA FOR ISS. For Intermediate Specialized Services (ISS), the client must have been evaluated through the Preadmission Screening and Resident Review (PASRR) 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.

009.08(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.

009.08(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).

009.08(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.

009.08(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).

009.08(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.

009.08(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 (PASRR) evaluation. A Tracking Form must be completed and faxed to the Department for clients with a Preadmission Screening and Resident Review (PASRR) determination.

009.08(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.

009.08(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.

009.08(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.

009.08(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.

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

009.08(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.

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

009.08(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).

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

010. MEDICAID HOSPICE BENEFIT.

010.01 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.

010.01(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).

010.02 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 review (PASRR) must be completed before the client is admitted to the facility.

010.02(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.

010.03 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.

010.03(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.

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

010.04 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.

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

010.05(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.

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

011. CIVIL MONEY PENALTY (CMP).

011.01 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.

011.01(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.

011.01(B) APPEAL. See 471 NAC 2.

011.02 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.

011.02(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.

011.02(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.

011.02(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).

011.03 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.

011.03(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.

011.03(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.

011.03(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).

011.03(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).

~~012. RATE METHODOLOGY. The Department will make the currently utilized rate methodology publicly available.~~

~~012.01 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.~~

01~~3~~312. NURSE AIDES IN NURSING FACILITIES.

01~~3~~312.01 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. § 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.

0~~13~~12.02 FACILITY RESPONSIBILITY.

0~~13~~12.02(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.

0~~13~~12.02(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.

0~~13~~12.02(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.

0~~13~~12.03 NURSE AIDE REQUIREMENTS.

0~~13~~12.03(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.

0~~13~~12.04 ESTABLISHMENT OF NURSE AIDE REGISTRY.

0~~13~~12.04(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. § 71-6039 and 172 NAC 108.

0~~13~~12.04(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.

01~~3~~12.04(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.

01~~3~~12.04(D) REMOVAL OF REGISTRY CONTENT.

01~~3~~12.04(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.

01~~3~~12.04(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.

0~~13~~12.04(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.

0~~13~~12.04(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.

0~~13~~12.04(D)(v) NOTIFICATION. Conditions for notification.

0~~13~~12.04(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.

0~~13~~12.04(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.

0~~13~~12.04(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.

0~~13~~12.04(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.

0~~13~~12.05 INVESTIGATION OF COMPLAINTS AND PLACEMENT OF ADVERSE FINDINGS.

0~~13~~12.05(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.

0~~13~~12.05(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.

0~~13~~12.05(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.

0~~13~~12.05(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 Procedure 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 Procedure Act.

0~~13~~12.05(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.

0~~13~~12.05(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 45 RATES FOR NURSING FACILITY SERVICES

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 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 471 Nebraska Administrative Code (NAC) 45-006.

002.02 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.

002.03 DEPARTMENT. As defined in Neb. Rev. Stat. § 68-907.

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

002.05 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.

002.06 INDIAN HEALTH SERVICES NURSING FACILITY PROVIDER. An Indian Health Services nursing facility or a tribal nursing facility designated as an Indian Health Services provider and funded by the Title I or ill of the Indian Self-Determination and Education Assistance Act, Public Law 93-638.

002.07 LEVEL OF CARE. The classification of each resident based on his or her acuity level.

002.08 MEDIAN. A value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

002.09 NURSING FACILITY. An institution, or a distinct part of an institution, which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

002.10 RATE DETERMINATION. Per diem rates calculated under provisions of this chapter. These rates may differ from rates actually paid for nursing facility services for Levels of Care 101, 102, 103 and 104.

002.11 RATE PAYMENT. Per Diem rates paid under provisions of 471 NAC 45. The payment rate for Levels of Care 101, 102, 103, and 104 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 Quality Assessment Component and the Quality Measures Component.

002.12 REVISIT FEES. Fees charged to health care facilities by the Secretary of Health and Human Services to cover the costs incurred under Centers for Medicare & Medicaid Services for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys.

002.13 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.

002.14 URBAN. Douglas, Lancaster, Sarpy, and Washington Counties. Rural means all other Nebraska counties.

002.15 WAIVERED FACILITY. Facilities for which the State Certification Agency has waived professional nurse staffing requirements of omnibus budget reconciliation act of 1987 are classified as waivered if the total number of waivered days exceeds 90 calendar days at any time during the reporting period.

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

003. GENERAL INFORMATION. Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions Medicare's Provider Reimbursement Manual, HIM-15, updated by provider reimbursement manual revisions in effect as of the beginning of each applicable cost report period are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety. That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under Medicaid except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities. Except for Indian Health Services nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year report period will not file a cost report.

004. ALLOWABLE COSTS. The following items are allowable costs under Medicaid:

004.01 COST OF MEETING LICENSURE AND CERTIFICATION STANDARDS. Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

(A) Meet the definition and requirements for a nursing facility of Title XIX of the Social Security Act, Section 1919;
(B) Comply with the standards prescribed by the Secretary of the Federal Health and Human Services for nursing facilities in 42 Code of Federal Regulations (CFR) 442;
(C) Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health standards, under 42 CFR 431.610; and
(D) Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.

004.02 ROUTINE SERVICES. Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services.

004.03 ANCILLARY SERVICES. Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as routine services. The facility must contract for ancillary services not readily available in the facility. If ancillary services are provided by a licensed provider or another licensed facility, the ancillary service provider must submit a separate claim for each client served. Allowable costs paid to physical, occupational, and speech therapists are limited to reasonable amounts paid for general consulting services plus reasonable transportation costs not covered through direct billing. General consulting services are not client specific, but instead, are staff related. These services include staff education, in-services and seminars. Respiratory therapy is an allowable cost. Department-required independent qualified mental retardation professional assessments are considered ancillary services.

004.04 PAYMENTS TO OTHER PROVIDERS. Items for which payment may be authorized to non-nursing facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service. Items for which payment may be authorized are:

(A) Legend drugs, over the counter drugs, and compounded prescriptions, including intravenous solutions and dilutants. Bulk supply over the counter drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility’s cost report;
(B) Personal appliances and devices, if recommended in writing by a physician;
(C) Orthoses, lower and upper limb, foot and spinal;
(D) Prostheses, breast, eye, lower and upper limb;
(E) Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care;
    (i) To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, Medicaid will not make payment for ambulance service; or

(ii) Non-emergency ambulance transports to a physician or practitioner's office, clinic, or therapy enter are covered when the client is bed confined before, during and after transport and when the services cannot or cannot reasonably be expected to be provided at the client's residence, including the nursing facility.

004.05 PAYMENTS TO NURSING FACILITY PROVIDER SEPARATE FROM PER DIEM RATES. Items for which payment may be made to nursing facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item outlined in the appropriate Medicaid provider chapter. Reimbursement to nursing facility providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of nursing facility services. The agency's fee schedule rate was set as of October 1, 2017, and is effective for services provided on or after that date. Items for which payment may be made are:

(A) Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use;
(B) Air fluidized bed units and low air loss bed units; and
(C) Negative pressure wound therapy.

005. UNALLOWABLE COSTS. The following costs are specifically unallowable:

(A) Provisions for income tax;
(B) Fees paid board of directors;
(C) Non-working officers' salaries;
(D) Promotion expenses, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing per local area telephone directory is allowable;
(E) Travel and entertainment, other than for professional meetings and direct operations of facility;
(F) Donations;
(G) Expenses of non-nursing home facilities and operations included in expenses;
(H) Insurance or annuity premiums on the life of the officer or owner;
(I) Bad debts, charity, and courtesy allowances;
(J) Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
(K) Services provided by the clients' physicians, therapists or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
(L) Return on equity;
(M) Carry-over of costs lost due to any limitation in this system;
(N) Expenses for equipment, facilities, and programs provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service; and
(O) Revisit fees.

006. LIMITATIONS FOR RATE DETERMINATION. The Department applies the following limitations for rate determination.

006.01 EXPIRATION OR TERMINATION OF LICENSE OR CERTIFICATION. The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under Medicaid. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under Medicaid.

006.02 TOTAL INPATIENT DAYS. In computing the provider's allowable per diem rates, total inpatient days are used. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year. Medicaid inpatient days are days for which claims or electronic Standard Health Care Claim: Institutional transaction, ASC X12N 837, from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a spenddown category are considered Medicaid inpatient days in compiling inpatient days. A facility may not impose charges that exceed the payment rate established under this chapter for these days. An inpatient day is:

(A) A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or

(B) A day on which the bed is held for hospital leave or therapeutic home visits.

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

006.04 COMMON OWNERSHIP OR CONTROL. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

(A) The supplying organization is a bona fide separate organization;

(B) A substantial part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;

(C) The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions. Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes

and employee benefits. The exception to the related party rule does not apply; and

(D) The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

006.05 LEASED FACILITIES. Allowable costs leased facilities including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of this chapter will apply. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

(A) Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and

(B) Make records available for audit upon request of the Department, the federal Department of Health and Human Services, or their designated representatives.

006.06 HOME OFFICE COSTS - CHAIN OPERATIONS. A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to healthcare. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating providers. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the cost report. Costs allocated under HIM-15, Section 2150.3.B, are limited to direct patient care services provided at the facility, and must be included in the applicable cost category. Costs allocated under HIM-15, Sections 2150.3C and 2150.3D, are included in the administration cost category. The Medicaid does not distinguish between capital related and non-capital related interest expense and interest income.

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

006.08 RECOGNITION OF FIXED COST BASIS. The fixed cost basis of real property, and personal property for facilities purchased on or after July 1, 2020, as an ongoing operation or for newly constructed facilities or facility additions is the lesser of, the acquisition cost of the asset to the purchaser; or for facilities purchased as an ongoing operation on or after July 1, 2020, the seller’s Medicaid net book value at the time of purchase. Costs, including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies,

attributable to the negotiation or settlement of the sale or purchase of any capital asset, by acquisition or merger, for which any payment has previously been made are not allowable.

006.09 SALARIES OF ADMINISTRATORS, OWNERS, AND DIRECTLY RELATED PARTIES. Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services. Beginning with the following calendar year base numbers for 12/31/2010, the Administrator Compensation Maximum Amounts can be calculated based on the following methodology.

006.09(A) 2010 BASE NUMBERS. The base numbers for 2010 to be used in the below calculation are: HIM%: 1.5%; Beds 0-74: 81,490; Beds 75-79: 82,954; Beds 100-149: 98,569; Beds 150-200: 99,544; Beds 200 or greater: 146,388.

006.09(B) CALCULATION. To determine the maximum amount for state fiscal year 2011, for each bed category, add 1 to the Calendar Year 2010 HIM % and multiply this amount by 50% of the Calendar Year 2010 bed total. To this amount add 50% of the Calendar Year 2010 bed total. For future years update the calendar year information above (A) by replacing the HIM % with the updated HIM % from HIM 15 Section 905.6.

006.09(C) COMPENSATION TO BE INCLUDED. All compensation received by an administrator is included in the administration cost category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: comparison to salaries paid for comparable position or positions within the specific facility, if applicable, or, if not applicable, then comparison to salaries for comparable position or positions as published by the Department of Administrative Services, Division of State Personnel in the State of Nebraska Salary Survey.

006.10 ADMINISTRATION EXPENSE. In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable direct nursing and support services components for the facility. This computation is made by dividing the total allowable direct nursing and support services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the direct nursing and support services components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

006.11 DIRECT NURSING COSTS. Direct nursing costs include cost report lines 94 through 103.

006.12 PLANT RELATED COSTS. Plant related costs include cost report lines 129 through 163.

006.13 EQUIPMENT LEASE AND MAINTENANCE AGREEMENTS. Costs of equipment lease or maintenance agreements that include or are tied to usage or supplies must be reported in the operating cost category that most closely relates to the equipment.

006.14 OTHER LIMITATIONS. Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

006.15 NURSING FACILITY QUALITY ASSESSMENT. The nursing facility quality assessment is an allowable cost addressed through the nursing facility quality assessment component.

007. RATE DETERMINATION. The Department determines rates for facilities under the following cost-based prospective methodology.

007.01 RATE PERIODS. The Rate Periods are defined as July 1 through December 31, and January 1 through June 30. Rates paid during the rate periods are determined from base year cost reports. For purposes of this section, base year cost reports means full and part-year cost reports filed with a base year report period ending date of June 30.

007.02 REPORT PERIOD. Each facility must file a cost report each year for the reporting period of July 1 through June 30 or part-year cost reports, when applicable.

007.03 CARE CLASSIFICATIONS. A portion of each individual facility's rate may be based on the urban or rural location of the facility.

007.04 PROSPECTIVE RATES. Subject to the allowable, unallowable, and limitation provisions of this chapter, the Department determines facility-specific prospective per diem rates, one rate corresponding to each level of care, based on the facility's allowable costs incurred and documented during the base year report period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the component maximums and minimums. Component maximums and minimums are computed using audited data following the initial desk audits, and are not revised based on subsequent changes to the data. Only cost reports with a full year's data are used in the computations. Cost reports from providers entering or leaving Medicaid during the immediately preceding report period are not used in the computations. Each facility's prospective rates are the sum of the following components; the direct nursing component adjusted by the inflation factor, and weighted for level of care; the support services component adjusted by the inflation factor; the fixed cost component; the nursing facility quality assessment component; and the quality measures component. The direct nursing component and the support services component are subject to maximum and minimum per diem payments based on Median or Maximum computations. For each care classification, the median for the direct nursing component is computed using nursing facilities within that care classification with an average occupancy of 40 or more residents, excluding waivered, or facilities with partial or initial or final full year cost reports. For each care classification, the median for the support services component is computed using nursing facilities within that care classification with an average occupancy of 40 or more residents, excluding hospital based, waivered, or facilities with partial or initial or final full year cost reports. The Department will reduce the direct nursing component median by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those

facilities' lowered nursing care costs. The maximum per diem is computed as 105% of the median direct nursing component, and 100% of the median support services component. The Department will reduce the direct nursing component maximum by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs. The minimum per diem is computed as 77% of the median direct nursing component, and 72% of the median support services component. The fixed cost component is subject to a maximum per diem of $27.00, excluding personal property and real estate taxes.

007.04(A) DIRECT NURSING COMPONENT. This component of the prospective rate is computed by dividing the base year allowable direct nursing costs, lines 94 through 103 of Form FA-66, Long Term Care Cost Report, by the base year weighted resident days for each facility. The resulting quotient is the facility's computed base year per diem. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

007.04(B) SUPPORT SERVICES COMPONENT. This component of the prospective rate is computed by dividing the base year allowable costs for support services, lines 34, 63, 78, 93, 104 through 127, 163, 184, and 185 from the FA-66; Resident Transportation - Medical from the Ancillary Cost Center, lines 211 through 218 from the FA-66; and respiratory therapy from the Ancillary Cost Center, lines 203 through 210 from the FA-66, by the total base year inpatient days for each facility. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

007.04(C) FIXED COST COMPONENT. This component of the prospective rate is computed by dividing the facility's base year allowable interest, depreciation, amortization, long-term rent or lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total base year inpatient days. Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, plus any prior approved increase under 471 NAC 45-007.05, or a maximum per diem of $27.00 excluding personal property and real estate taxes.

007.04(D) NURSING FACILITY QUALITY ASSESSMENT COMPONENT. The Nursing Facility Quality Assessment component shall not be subject to any cost limitation or revenue offset. For purposes of this section, facilities exempt from the quality assurance assessment are: state-operated veterans' homes; nursing facilities and skilled nursing facilities with twenty-six or fewer licensed beds; and continuing care retirement communities. the quality assessment component rate will be determined by calculating the anticipated tax payment' during the rate year and then dividing the total anticipated tax payments by total anticipated nursing facility or skilled nursing facility patient days, including bed hold days and Medicare patient days. for each rate year, July 1 through the following June 30, total facility patient days, including bed hold days, less Medicare days, for the four most recent calendar quarters available at the time rates are determined will be used to calculate the anticipated tax payments. Total facility patient days, including bed hold days and Medicare days, for the same four calendar quarters will be used to calculate the anticipated nursing facility or skilled nursing facility patient days. for new providers entering the Medicaid program to operate a nursing facility not previously

enrolled in Medicaid, for the rate period beginning on the Medicaid certification date through the following June 30, the quality assessment rate component is computed as the quality assurance assessment amount due from the provider's first quality assurance assessment form covering a full calendar quarter, divided by total resident days in licensed beds from the same quality assurance assessment form. for existing providers changing from exempt to non-exempt status, for the rate period beginning on the first day of the first full month the provider is subject to the quality assurance assessment through the following June 30, the quality assessment rate component is computed as the quality assurance assessment amount due from the provider's first quality assurance assessment form covering a full calendar quarter, divided by total resident days in licensed beds from the same quality assurance assessment form. For existing providers changing from non-exempt to exempt status, for rate periods beginning with the first day of the first full month the provider is exempt from the quality assurance assessment, the quality assessment rate component will be $0.00 (zero dollars).

007.04(E) BASE YEAR REPORT PERIOD AND INFLATION FACTOR. For the Rate Periods July 1 through December 31, 2020, and January 1 through June 30, 2021, the base year is the report period ending June 30, 2018; and the inflation factor is positive 1.51%.

007.04(F) QUALITY MEASURES COMPONENT. This component of the prospective rate is based on the quality measures component of the Centers for Medicare & Medicaid nursing facility star rating system. The published rating as of May 1 is used to determine the rate component for the following July 1 through December 31 rate period. The published rating as of November 1 is used to determine the rate component for the following January 1 through June 30 rate period. Per diem amounts corresponding to the quality measures rating are: 5 star rating = $10.00 a day; 4 star rating = $6.75 a day; 3 star rating = $3.50 a day; 1 star, 2 star, or NR (no rating) = $0.00 (zero dollars). This component applies to all nursing facility care levels (101-180).

007.05 EXCEPTION PROCESS. An individual facility may request, on an exception basis, the Medicaid Director or designee, to consider specific facility circumstance or circumstances, which warrant an exception to the facility's rate computed for its fixed cost component. For existing facilities, an exception may only be requested if the facility's total annualized fixed costs, total costs, not per diem rate, as compared to the annualized base year costs, have increased by twenty percent or more. Facilities without a base year cost report, and with 1,000 or more annualized Medicaid days, may only request an exception if the facility's fixed costs per day, computed using an 85% minimum occupancy, exceeds the care classification average fixed cost component by 20% or more. In addition, the facility's request must include: Specific identification of the increased cost or costs that have caused the facility's total fixed costs to increase by 20% or more, with justification for the reasonableness and necessity of the increase; Whether the cost increase or increases are an ongoing or a one-time occurrence in the cost of operating the facility; and If applicable, preventive management action that was implemented to control past and future cause or causes of identified cost increase or increases. Approved increases from July 1 through December 31, will be effective the following January 1. Approved increases from January 1 through June 30, will be effective the following July 1.

007.06 RATE PAYMENT FOR LEVELS OF CARE 101, 102, 103, AND 104. The payment rate for Levels of Care 101, 102, 103, and 104 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 quality assessment component and quality measures component.

007.07 OUT-OF-STATE FACILITIES. The Department pays out-of-state facilities participating in Medicaid at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

007.08 RATES FOR PROVIDERS WITHOUT A BASE YEAR COST REPORT. A provider without a base year cost report is an individual or entity which obtains their initial, facility-specific provider agreement to operate an existing nursing facility, meaning the business operation, not the physical property, due to a change in ownership, or to operate a nursing facility not previously enrolled in Medicaid, after the base year cost report end date; or a provider with 1,000 or fewer Medicaid inpatient days in the base year. Prospective Medicaid rates for providers without a base year cost report are the sum of the following components:

(A) The applicable urban or rural average direct nursing base rate component of all other providers in the same care classification, adjusted by the inflation factor; and weighted for level of care;
(B) The applicable urban or rural average support services base rate component of all other providers in the same care classification, adjusted by the inflation factor;
(C) The applicable urban or rural average fixed cost base rate component of all other providers in the same care classification;
(D) The Nursing Facility Quality Assessment component; and
(E) The quality measures component.

007.09 PROVIDERS LEAVING THE MEDICAID. Providers leaving Medicaid as a result of change of ownership or exit from the program shall comply with provisions of this chapter.

007.10 SPECIAL FUNDING PROVISIONS FOR GOVERNMENTAL FACILITIES. City and county-owned and operated nursing facilities are eligible to receive the federal financial participation share of allowable costs exceeding the rates paid for the direct nursing, support services, and fixed cost Components for all Medicaid residents. The reimbursement is subject to the payment limits of 42 CFR 447.272.

007.10(A) CITY OR COUNTY OWNED FACILITIES. City or county-owned facilities with a 40% or more Medicaid mix of inpatient days are eligible to receive the federal financial participation share of allowable costs exceeding the applicable maximums for the direct nursing, support services, and fixed cost components. This amount is computed after desk audit and determination of final rates for a report period by multiplying the current Medicaid federal financial participation percentage by the facility's allowable costs above the respective maximum for the direct nursing, support services, and fixed cost components. Verification of the eligibility of the expenditures for federal financial participation is accomplished during the audit process.

007.11 SPECIAL FUNDING PROVISIONS FOR INDIAN HEALTH SERVICES NURSING FACILITY PROVIDERS. Indian Health Services nursing facility providers are eligible to receive the federal financial participation share of allowable costs exceeding the rates paid for the direct nursing, support services, and fixed cost components for all Medicaid residents.

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

(i) Quarterly, interim special funding payments shall be made within 30 days of receipt of the quarterly cost report or requested supporting documentation. Quarterly, interim special funding payments subsequent to the payment for the final quarterly cost report shall be made on or about 90-day intervals following the previous payment.

(ii) The special funding amount is computed after desk audit and determination of allowable costs for the report period. The amount is calculated by adding the following two figures:

(a) The allowable federal medical assistance percentage for Indian Health Services-eligible Medicaid residents multiplied by the difference between the allowable costs for all Indian Health Services-eligible Medicaid residents and the total amount paid for all Indian Health Services-eligible Medicaid residents, if greater than zero: and

(b) The allowable federal medical assistance percentage for non-Indian Health Services-eligible Medicaid residents multiplied by the difference between the allowable costs for all non-Indian Health Services-eligible Medicaid residents and the total amount paid for all non-Indian Health Services-eligible Medicaid residents, if greater than zero.

008. DEPRECIATION. This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements, Medicare's Provider Reimbursement Manual, HIM-15, Section 110, are retained, subject to the following Medicaid depreciation regulations. At the time of an asset acquisition, the nursing facility must use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life.

008.01 CAPITALIZATION GUIDELINES. Providers must devise and follow a written capitalization policy within the following guidelines. A copy of the policy must be available upon request by the Department.

008.01(A) CAPITALIZATION THRESHOLD. The capitalization threshold is a pre-determined amount at which asset purchases must be capitalized rather than expensed. Each provider determines the capitalization threshold for their facility, but the threshold amount must be at least $100 and no greater than $5,000.

008.01(B) ACQUISITIONS. If a depreciable asset has at the time of its acquisition an estimated useful life of at least two years and an allowable cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has an allowable cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

008.01(C) ACQUISITIONS UNDER $100. Acquisitions after July 1, 2005 with a per unit cost of less than $100 cannot be depreciated. Costs of these items are included in the applicable operating cost category on the cost report in the current period.

008.01(D) INTEGRATED SYSTEM PURCHASES. When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold.

008.01(E) MULTIPLE ITEMS WITH PER UNIT COST GREATER THAN OR EQUAL TO $100. Items that have a stand-alone functional capability may be considered on an item-by-item basis or as an aggregate single purchase. Each provider's capitalization policy must describe how the provider elects to treat these items.

008.01(F) NON-CAPITAL PURCHASES. Purchases of equipment and furnishings over $100 per item and under the provider's capitalization threshold are included in the Plant Related cost category on the Cost Report in the current period.

008.01(G) BETTERMENTS AND IMPROVEMENTS. Betterments and improvements extend the life, increase the productivity, or significantly improve the safety of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

008.02 BUILDINGS AND EQUIPMENT. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

(A) Identifiable and recorded in the provider's accounting records;

(B) Based on book value of the asset or assets in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;

(C) Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation;

(D) Based on the fair market value at the time of donation for donated assets without a prior Medicaid basis; or based on the donor's Medicaid net book value at the time of the donation for donated assets with a prior Medicaid basis. Depreciation on donated

assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and

(E) Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

008.03 OTHER GAINS AND LOSSES ON DISPOSITION OF ASSETS. Losses on the sale of real property are not recognized under Medicaid. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains or losses on personal property will be reduced from or included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

008.04 SALE OR TRANSFER OF CORPORATE STOCK. Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

009. REPORTING REQUIREMENTS AND RECORD RETENTION. Providers with greater than 1,000 Medicaid inpatient days for a full Report Period must submit cost and statistical data on Form FA-66, Report of Long Term Care Facilities for Reimbursement. Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation will prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes. Each facility must complete the required schedules and submit the original, signed report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in Medicaid. Under extenuating circumstances, an extension not to exceed 45 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due. When a provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider must maintain levels of care if the Department suspends payment. If the provider takes no action to comply with the obligation, the Department may refer the case for legal action. If a required cost report has not been filed, the sum of the following is due: all prospective rate payments made during the rate period to which the cost report applies; all prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and costs incurred by the department in attempting to secure reports and payments. If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing. Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating

to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department will retain all cost reports for at least five years after receipt from the provider. Facilities which provide any services other than certified nursing facility services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the rep ort period. A Medicare certified facility must not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

009.01 DISCLOSURE OF COST REPORTS. Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Division. The request must include the name, including an individual to contact, address, and telephone number of the individual or organization making the request; the nursing facility name, location, and report period for the cost report requested; and directions for handling the request, review the reports at the Department's Lincoln State Office Building address; pick up copies at that office; or mail copies. The total fee, based on current Department policy, must be paid in advance. The nursing facility will receive a copy of a request to inspect its cost report.

010. AUDITS. The Department will perform at least one initial desk audit and may perform subsequent desk audits or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit. An initial desk audit will be completed on all cost reports. Care classification maximums and average base rate components are computed using audited data following the end of the Cost Report Period. Subsequent desk and field audits will not result in a revision of care classification maximums or average base rate components. All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period or periods and subject or subjects to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider must deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit. All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period or periods to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

011. SETTLEMENT AND RATE ADJUSTMENTS. When an audit has been completed on a cost report, the Department will determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on a remittance advice. Payment or arrangements for payment of the settlement amount, by either the

Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion. The Department will determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department will immediately begin recovery from future facility payments until the amount due is fully recovered. The Department will report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

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

013. APPEAL PROCESS. Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Division Director. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis or explanation of each item, or both. After the Division Director issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

014. ADMINISTRATIVE FINALITY. Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction. Reopening means an action taken by the Division Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Division Director is the sole authority in deciding whether to reopen. The action may be taken: on the initiative of the Department within the three-year period; in response to a written request from a provider or other entity within the three-year period. Whether the Division Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or anytime fraud or abuse is suspected. A provider does not have the right to appeal a finding by the Division Director that a reopening or correction of a determination or decision is not warranted.

015. CHANGE OF HOLDER OF PROVIDER AGREEMENT. A holder of a provider agreement receiving payments under 12-011 must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by

payment of that amount to the Department, providing evidence that another provider receiving payments under this chapter has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership. The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

016. CLASSIFICATION OF RESIDENTS AND CORRESPONDING WEIGHTS.

016.01 RESIDENT LEVEL OF CARE. The Department will use a federally-approved resource utilization group grouper to assign each resident to a level of care based on information contained on his or her minimum data set assessment. Each level of care will be assigned the federally-recommended weight. When no minimum data set assessment is available, the resident will be assigned to a default level of care, Level 180.

016.02 WEIGHTING OF RESIDENT DAYS USING RESIDENT LEVEL OF CARE AND WEIGHTS. Each facility resident is assigned to a level of care. Each resident's level of care is appropriately updated from each assessment to the next the admission assessment, a significant change assessment, the quarterly review, the annual assessment, etc., and is effective for payment purposes on the first day of the month of the applicable assessment if it is received by the tenth day of the month of the applicable assessment. A change in resident level of care which results from an audit of assessments is retroactive to the effective date of the assessment which is audited. For purposes of the Medicaid case mix system, the Department does not change an assessment record. A record modification may replace an existing record in the Centers for Medicare & Medicaid Services minimum data set data base, but the Department will not replace the existing record in the Medicaid case mix system. The record modification will be processed by the Department as an original record. This means that the Department will process the record in the usual manner if the record is not already in the case mix system. The Department will reject the record as a duplicate if the record has already been accepted into the case mix system. The Department will inactivate a discharge or re-entry tracking record but not an assessment. For each reporting period, the total resident days, per the minimum data set system, at each care level are multiplied by the corresponding weight. The resulting products are summed to determine the total weighted resident days per the minimum data set system. This total is then divided by the minimum data set total resident days per the minimum data set system. This total is then divided by the minimum data set total resident days and multiplied by total resident days per the facility's Medicaid cost report to determine the total number of weighted resident days for the facility, which is the divisor for the direct nursing component.

016.03 RESIDENT LEVEL OF CARE WEIGHTS. The following weighting factors must be assigned to each resident level of care, based on the Centers for Medicare and Medicaid Services Resource Utilization Groups Ill 5.20 version:

(A) Level of care: 163; Casemix Index Vaue: RAD; Casemix Index Description: Rehabilitation/ADL = 17-18; Casemix Index Value: 1.66;

(B) Level of care: 162; Casemix Index Vaue: RAC; Casemix Index Description: Rehabilitation/ADL = 14-16; Casemix Index Value: 1.31;

(C) Level of care: 161; Casemix Index Vaue: RAB; Casemix Index Description: Rehabilitation/ADL = 4-8; Casemix Index Value: 1.24;

(D) Level of care: 160; Casemix Index Vaue: RAA; Casemix Index Description: Rehabilitation/ADL = 17-18; Casemix Index Value: 1.07;

(E) Level of care: 172; Casemix Index Vaue: SE3; Casemix Index Description: Extensive Services 3/ADL >6; Casemix Index Value: 2.10;

(F) Level of care: 171; Casemix Index Vaue: SE2; Casemix Index Description: Extensive Services 2/ADL >6; Casemix Index Value: 1.79;

(G) Level of care: 170; Casemix Index Vaue: SE1; Casemix Index Description: Extensive Services 1/ADL >6; Casemix Index Value: 1.54;

(H) Level of care: 152; Casemix Index Vaue: SSC; Casemix Index Description: Special Care/ADL = 17-18; Casemix Index Value: 1.44;

(I) Level of care: 151; Casemix Index Vaue: SSB; Casemix Index Description: Special Care/ADL = 15-16; Casemix Index Value: 1.33;

(J) Level of care: 150; Casemix Index Vaue: SSZ; Casemix Index Description: Special Care/ADL = 4-14; Casemix Index Value: 1.28;

(K) Level of care: 145; Casemix Index Vaue: CC2; Casemix Index Description: Clinically Complex w/Depression/ADL = 17-18; Casemix Index Value: 1.42;

(L) Level of care: 144; Casemix Index Vaue: CC1; Casemix Index Description: Clinically Complex/ADL = 17-18; Casemix Index Value: 1.25;

(M) Level of care: 143; Casemix Index Vaue: CB2; Casemix Index Description: Clinically Complex w/ Depression/ADL = 12-16; Casemix Index Value: 1.15;

(N) Level of care: 142; Casemix Index Vaue: CB1; Casemix Index Description: Clinically Complex/ADL = 12-16; Casemix Index Value: 1.07;

(O) Level of care: 141; Casemix Index Vaue: CA2; Casemix Index Description: Clinically Complex w/Depression/ADL = 4-11; Casemix Index Value: 1.06;

(P) Level of care: 140; Casemix Index Vaue: CA1; Casemix Index Description: Clinically Complex/ADL = 4-11; Casemix Index Value: 0.95;

(Q) Level of care: 133; Casemix Index Vaue: IB2; Casemix Index Description: Cognitive Impairment with Nursing Rehab/ADL= 6-10; Casemix Index Value: 0.88;

(R) Level of care: 132; Casemix Index Vaue: IB1; Casemix Index Description: Cognitive Impairment/ADL = 6-10; Casemix Index Value: 0.85;

(S) Level of care: 131; Casemix Index Vaue: IA2; Casemix Index Description: Cognitive Impairment with Nursing Rehab/ADL = 4-5; Casemix Index Value: 0.72;

(T) Level of care: 130; Casemix Index Vaue: IA1; Casemix Index Description: Cognitive Impairment/ADL = 4-5; Casemix Index Value: 0.67;

(U) Level of care: 123; Casemix Index Vaue: BB2; Casemix Index Description: Behavior Prob w/Nursing Rehab/ADL = 6-10; Casemix Index Value: 0.86;

(V) Level of care: 122; Casemix Index Vaue: BB1; Casemix Index Description: Behavior Prob/ADL = 6-10; Casemix Index Value: 0.82;

(W) Level of care: 121; Casemix Index Vaue: BA2; Casemix Index Description: Behavior Prob w/Nursing Rehab/ADL = 4-5; Casemix Index Value: 0.71;

(X) Level of care: 120; Casemix Index Vaue: BA1; Casemix Index Description: Behavior Prob/ADL = 4-5; Casemix Index Value: 0.60;

(Y) Level of care: 115; Casemix Index Vaue: PE2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 16-18; Casemix Index Value: 1.00;

(Z) Level of care: 114; Casemix Index Vaue: PE1; Casemix Index Description: Physical Function/ADL = 16-18; Casemix Index Value: 0.97;

(AA) Level of care: 113; Casemix Index Vaue: PD2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 11-15; Casemix Index Value: 0.91;
(BB) Level of care: 112; Casemix Index Vaue: PD1; Casemix Index Description: Physical Function/ADL = 11-15; Casemix Index Value: 0.89;
(CC) Level of care: 111; Casemix Index Vaue: PC2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 9-10; Casemix Index Value: 0.83;
(DD) Level of care: 110; Casemix Index Vaue: PC1; Casemix Index Description: Physical Function/ADL = 9-10; Casemix Index Value: 0.81;
(EE) Level of care: 104; Casemix Index Vaue: PB2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 6-8; Casemix Index Value: 0.65;
(FF) Level of care: 103; Casemix Index Vaue: PB1; Casemix Index Description: Physical Function/ADL = 6-8; Casemix Index Value: 0.63;
(GG) Level of care: 102; Casemix Index Vaue: PA2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 4-5; Casemix Index Value: 0.62;
(HH) Level of care: 101; Casemix Index Vaue: PA1; Casemix Index Description: Physical Function/ADL = 4-5; Casemix Index Value: 0.59; or
(II) Level of care: 180; Casemix Index Vaue: STS; Casemix Index Description: Short-Term Stay; Casemix Index Value: 0.59; Level of Care 180, Short-Term Stay, is used for stays of less than 14 days when a client is discharged and the facility does not complete a full minimum data set admission assessment of the client. This is effective for admissions on or after July 1, 2010.

016.04 VERIFICATION. Resident assessment information is audited as a procedure in the Department of Health and Human Services Division of Public Health, Survey and Certification process.

017. SPECIALIZED ADD-ON SERVICES PAYMENTS. Specialized add-on services are paid to the provider or 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.

017.01 SPECIALIZED ADD-ON SERVICES. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of specialized add-on services provided in the nursing facility. The Medicaid agency's rates were set as of June 30, 2018, and are effective for dates of services provided on and after that date.

017.02 HABILATIVE SERVICES. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of habilitative services, provided to individuals residing in a nursing facility. The rates for these specialized add-on services were established using existing developmental disabilities waiver fee schedules. The rates were set as of June 30, 2018 and are effective for dates of service provided on and after that date.

017.03 SUPERVISORY ACTIVITIES. Payment excludes the supervisory activities rendered as a normal part of the employment support.

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

018.01 NEBRASKA FACILITIES. To establish a Nebraska facility's payment rate for care of special needs clients:

(A) The facility must submit Form FA-66, Long Term Care Cost Report, to the Department for each fiscal year ending June 30. Medicare cost reporting forms may be substituted when Form FA-66 is not otherwise required to be submitted. Form FA-66 must be completed in accordance with this chapter, Completion of Form FA-66, Long Term Care Cost Report, Rates for Nursing Facility Services, as applicable. Medicare cost reports must be completed in accordance with Medicare's Provider Reimbursement Manual (HIM15). If the facility provides both nursing facility services and special needs services, direct accounting or cost allocations necessary to distribute costs between the nursing facility and the special needs unit must be approved by the Department;

(B) The Department shall compute the allowable cost per day from the most recent State fiscal year Form FA-66 or the most recent Medicare cost report, as applicable, which will be the basis from which a prospective rate is negotiated. Payment for fixed costs is limited to the lower of the individual facility's fixed cost per diem or a maximum per diem of $54.00 excluding personal property and real estate taxes. Negotiations may include, but are not limited to, discussion of appropriate inflation or deflation expectations for the rate period and significant increases or decreases in the cost of providing services that are not reflected in the applicable cost report;

(C) If the facility has no prior cost experience in providing special needs services, the facility must submit a budget for the provision of the intended service. The Department must concur that the budgeted cost per day meets a reasonable expectation of the cost of providing said service, taking into account the cost per day of similar facilities providing similar services. Budgets will be used until the facility has at least six months of actual cost experience;

(D) An incentive factor calculated at eight per cent of allowable costs is added to the allowable costs of proprietary facilities. An incentive factor calculated at four percent of allowable costs is added to the allowable costs of other than propriety facilities;

(E) After a rate is agreed upon, the provider must sign a provider agreement addendum. The addendum originated by the Department, must include:

(i) The rate and its applicable dates;

(ii) A description of the criteria for care; and

(iii) A full description of the services to be provided under the established per diem as well as any services that are not provided under the per diem and are billed separately; and

(F) Reimbursement must reflect the facility’s actual reasonable cost of providing services to special needs clients and must be updated annually using an appropriate inflation adjustment.

018.02 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 Medicaid provider agreement. The payment is not subject to any type of adjustment.

018.03 PAYMENT FOR BEDHOLD. The Medicaid payment rate for hospital and therapeutic leave days will be negotiated between the service provider and the Department based on the costs of operating a special needs unit. The rate will be no lower than the Level 105 rate, as defined in this chapter, and will not exceed the per diem inpatient unit rate.

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 46 RATES FOR HOSPITAL SERVICES

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

002.02 ALL PATIENT REFINED-DIAGNOSIS RELATED GROUP ALL PATIENT REFINED DIAGNOSIS RELATED GROUP. A diagnosis related group classification system.

002.03 BASE YEAR. The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

002.04 BUDGET NEUTRALITY. Payment rates are adjusted for budget neutrality such that estimated expenditures for the current rate year are not greater than expenditures for the previous rate year, trended forward.

002.05 CAPITAL-RELATED COSTS. Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

002.06 CASE-MIX INDEX. An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

002.07 COST OUTLIER. Cases which have an extraordinarily high cost as established in this chapter so as to be eligible for additional payments above and beyond the initial diagnosis related group payment.

002.08 CRITICAL ACCESS HOSPITAL. A hospital certified for participation by Medicare as a Critical Access Hospital.

002.09 DIAGNOSIS-RELATED GROUP. A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

002.10 DIRECT MEDICAL EDUCATION COST PAYMENT. An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.

002.11 DISPROPORTIONATE SHARE HOSPITAL. A hospital located in Nebraska is deemed to be a disproportionate share hospital by having:

(A) A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or

(B) A low-income utilization rate of 25 percent or more.

002.12 DISTINCT PART UNIT. A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

002.13 DIAGNOSIS RELATED GROUP Weight. A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each diagnosis related group and severity of illness.

002.14 HOSPITAL MERGERS. Hospitals that have combined into a single corporate entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

002.15 HOSPITAL-SPECIFIC BASE YEAR OPERATING COST. Hospital specific operating allowable cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

002.16 HOSPITAL-SPECIFIC COST-TO-CHARGE RATIO. Hospital-specific cost-to-charge ratio is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-specific cost-to-charge ratios used for outlier cost payments and transplant diagnosis related group cost-to-charge ratios payments are derived from the outlier cost-to-charge ratios in the Medicare inpatient prospective payment system.

002.17 INDIRECT MEDICAL EDUCATION COST PAYMENT. Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education payments.

002.18 LOW-INCOME UTILIZATION RATE. For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum, expressed as a percentage, of the fractions, calculated from acceptable data submitted by the hospital as follows:

(A) Total Medicaid inpatient revenues including fee-for-service, managed care, and primary care case management payments, excluding payments for disproportionate share hospitals, paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services including fee-for-service, managed care, and primary care case management payments, including the

amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals, in the same cost reporting period; and

(B) The total amount of the hospital's charges for hospital inpatient services attributable to indigent care in ending in the calendar year preceding the Medicaid rate period, less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to indigent care does not include contractual allowances and discounts, other than for indigent patients not eligible for Medicaid, that is, reductions in charges given to other third-party payors, such as health maintenance organizations, Medicare, or Blue Cross.

002.19 MEDICAID ALLOWABLE INPATIENT CHARGES. Total claim submitted charges less claim non-allowable amount.

002.20 MEDICAID ALLOWABLE INPATIENT DAYS. The total number of covered Medicaid inpatient days.

002.21 MEDICAID INPATIENT UTILIZATION RATE. The ratio of allowable Medicaid inpatient days, as determined by Nebraska Medicaid, to total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out–of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

002.22 MEDICAID RATE PERIOD. The period of July 1 through the following June 30.

002.23 MEDICAL REVIEW. Review of Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay, completeness, adequacy, and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

002.24 MEDICARE COST REPORT. The report filed by each facility with its Medicare fiscal intermediary.

002.25 NATIONAL WEIGHTS. The 3M APR-DRG National Weights are calculated using the Nationwide Inpatient Sample released by the Healthcare Cost and Utilization Project. A hospital that does not participate in the Medicare program shall complete the Medicare Cost Report in compliance with Medicare principles and supporting rules, regulations, and statutes. The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees. If a nursing facility is affiliated with the hospital, the nursing facility cost report must be filed according to this chapter. Note specifically that time guidelines for filing nursing facility cost reports differ from those for hospitals.

002.26 NEW OPERATIONAL FACILITY. A facility providing inpatient hospital care which meets one of the following criteria:

(A) A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;

(B) A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or

(C) A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months. A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

002.27 OPERATING COST PAYMENT AMOUNT. The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

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

(A) Metro acute care hospitals: Peer Group 1: Hospitals located in metropolitan statistical areas as designated by Medicare;

(B) Other urban acute care hospitals: Peer Group 2: Hospitals that have been redesignated to a metropolitan statistical area by Medicare for federal fiscal year 1995 or 1996 or hospitals designated by Medicare as regional rural referral centers;

(C) Rural acute care hospitals: Peer Group 3: All other acute care hospitals;

(D) Psychiatric hospitals and distinct part units in acute care hospitals: Peer Group 4: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;

(E) Rehabilitation hospitals and distinct part units in acute care hospitals: Peer Group 5: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and

(F) Critical access hospital: Peer Group 5: Hospitals that are certified as critical access hospitals by Medicare.

002.29 PEER GROUP BASE PAYMENT AMOUNT. A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The base payment amount is the same for all hospitals in a peer group except Peer Group 1, Children's Hospitals, Peer Group 5 and Peer Group 6.

002.30 REPORTING PERIOD. Same reporting period as that used for its Medicare cost report.

002.31 RESOURCE INTENSITY. The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

002.32 RISK OF MORTALITY (ROM). The likelihood of dying.

002.33 SEVERITY OF ILLNESS LEVEL (SOI). The extent of physiologic decompensation or organ system loss of function.

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

002.35 UNCOMPENSATED CARE. Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

003. PAYMENT FOR PEER GROUPS 1, 2, AND 3 METRO ACUTE, OTHER URBAN ACUTE, AND RURAL ACUTE. Payments for acute care services are made on a prospective per discharge basis, except hospitals certified as a critical access hospital. For inpatient services that are classified into a diagnosis related group, the total per discharge payment is the sum of the operating cost payment amount; the capital-related cost payment; and when applicable direct medical education cost payment; indirect medical education cost payment; and a cost outlier payment. For inpatient services that are classified into a transplant diagnosis related group, the total per discharge payment is the sum of the cost-to-charge ratio payment amount; and when applicable direct medical education cost payment.

003.01 DETERMINATION OF OPERATING COST PAYMENT AMOUNT. The hospital diagnosis related group operating cost payment amount for discharges that are classified into a diagnosis related group is calculated by multiplying the peer group base payment amount by the applicable national relative weight.

003.01(A) CALCULATION OF THE APR-DIAGNOSIS RELATED GROUP WEIGHTS. For dates of service on or after July 1, 2014, the Department will use the All-Patient Refined Diagnosis Related Groups classifications. The National Weights published by 3M will be applied to the all patient refined-diagnosis related groups. The National Weights are calculated using the nationwide inpatient sample released by the healthcare cost and utilization project. The Department will annually update the all patient refined-diagnosis related group grouper and national relative weights with the most current available version.

003.01(B) CALCULATION OF NEBRASKA PEER GROUP BASE PAYMENT AMOUNTS. Peer group base payment amounts are used to calculate payments for discharges with a diagnosis related group. Peer group base payment amounts effective July 1, 2016, are calculated for peer group 1, 2 and 3 hospitals based on the peer group base payment amounts effective during state fiscal year 2011, adjusted for budget neutrality, calculated as follows: peer group 1 base payment amounts, excluding children's hospitals: multiply the state fiscal year 2011 peer group 1 base payment amount of $4,397.00 by the diagnosis related group budget neutrality factor. Children’s hospital peer group 1 base payment amounts: multiply the state fiscal year 2011 children's hospital peer group 1 base payment amount of $5,278.00 by the diagnosis related group budget neutrality factor. Peer group 2 base payment amounts: multiply the state fiscal year 2011 peer group 2 base payment amount of $4,270.00 by the diagnosis related group budget neutrality factor. Peer group 3 base payment amounts: multiply the state fiscal year 2011

peer group 3 base payment amount of $4,044.00 by the diagnosis related group budget neutrality factor. State fiscal year 2007 Nebraska peer group base payment amounts are described in this chapter. Peer group base payment amounts excluding the 0.5% increase for the rate period beginning October 1, 2009 and ending June 30, 2010, will be increased by .5% for the rate period beginning July 1, 2010. The peer group base payment amount effective July 1, 2010 will be reduced by 2.5% effective July 1, 2011. The peer group base payment amount effective July 1, 2011 will be increased by 1.54% effective July 1, 2012. The peer group base payment amount effective July 1, 2012 will be increased by 2.25% effective July 1, 2013. The peer group base payment amount effective July 1, 2013 will be increased by 2.25% effective July 1, 2014. The peer group base payment amount effective July 1, 2014 will be increased by 2% effective July 1, 2015. The peer group base payment amount effective July 1, 2015, will be increased by 2% effective July 1, 2016. The peer group base payment amount effective July 1, 2016, will be increased by 2% effective July 31, 2019. The peer group base payment amount effective July 31, 2019, will be increased by 2% effective July 1, 2020.

003.02 CALCULATION OF DIAGNOSIS RELATED GROUP COST OUTLIER PAYMENT AMOUNTS. Additional payment is made for approved discharges classified into a diagnosis related group meeting or exceeding Medicaid criteria for cost outliers for each diagnosis related group classification. Cost outliers may be subject to medical review. Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $30,000 for all neonate and nervous system all patient refined-diagnosis related groups at severity level 3 and at severity level 4. For all other all patient refined-diagnosis related groups, the outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $51,800. Cost of the discharge is calculated by multiplying the Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier cost-to-charge ratios. Additional payment for cost outliers is 80% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85% of the difference between the hospital’s cost for the discharge and the outlier threshold.

003.02(A) HOSPITAL SPECIFIC MEDICARE OUTLIER CCRS. The Department will extract from the Center for Medicaid and Medicaid Services Prospective Payment System Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier cost-to-charge ratios effective October 1 of the year preceding the start of the Nebraska rate year.

003.02(B) OUTLIER CCRS UPDATES. On July 1 of each year, the Department will update the outlier costs based on the Medicare outlier cost-to-charge ratios effective October 1 of the previous year.

003.03 CALCULATION OF MEDICAL EDUCATION COSTS.

003.03(A) CALCULATION OF DIRECT MEDICAL EDUCATION COST PAYMENTS. Direct Medical Education payments effective October 1, 2009 are based on Nebraska hospital-specific direct medical education payment rates effective during state fiscal year

2007 with the following adjustments: Estimate state fiscal year 2007 direct medical education payments for in-state teaching hospitals by applying state fiscal year 2007 direct medical education payment rates to state fiscal year 2007 Nebraska Medicaid inpatient fee-for-service paid claims data. Include all patient refined-diagnosis related group discharges except psychiatric, rehabilitation and Medicaid Capitated Plans discharges. Divide the estimated state fiscal year 2007 direct medical education payments for each hospital by each hospital's number of intern and resident full time equivalents effective in the Medicare system on October 1, 2006. Multiply the state fiscal year 2007 direct medical education payment per intern and resident full time equivalent by each hospital's number of intern and resident full time equivalents effective in the Medicare inpatient system on October 1, 2008. Divide the direct medical education payments adjusted for full time equivalents effective October 1, 2008 by each hospital's number of state fiscal year 2007 claims. Multiply the direct medical education payment rates by the stable diagnosis related group budget neutrality factor. On July 1st of each year, the Department will update direct medical education payment rates by replacing each hospital's intern and resident full time equivalents effective in the Medicare inpatient system on October 1, 2008, as described in step 3 of this subsection, with each hospital's intern and resident full time equivalents effective in the Medicare inpatient system on October 1 of the previous year. The direct medical education payment amount will be increased by 0.5% effective October 1, 2009 through June 30, 2010. This rate increase will not be carried forward in subsequent years. The direct medical education payment amount, excluding the 0.5% increase effective October 1, 2009 through June 30, 2009, will be increased by .5% for the rate period beginning July 1, 2010. Effective July 1, 2011, the direct medical education amount shall be reduced by 2.5%. Effective July 1, 2012, the direct medical education amount shall be increased by 1.54%. Effective July 1, 2013, the direct medical education amount shall be increased by 2.25%. Effective July 1, 2014, the direct medical education amount shall be increased by 2.25%. Effective July 1, 2015, the direct medical education amount shall be increased by 2%. Effective July 1, 2016, the direct medical education amount shall be increased by 2%. Effective July 31, 2019, the direct medical education amount shall be increased by 2%. Effective July 1, 2020, the direct medical education amount shall be increased by 2%.

003.03(B) CALCULATION OF INDIRECT MEDICAL EDUCATION COST PAYMENTS. Hospitals qualify for indirect medical education payments when they receive a direct medical education payment from Medicaid, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an indirect medial education factor by the operating cost payment amount. The indirect medical education factor is the Medicare inpatient prospective payment system operating indirect medial education factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating indirect medical education factor shall be determined using data extracted from the Center for Medicare and Medicaid Services Prospective Payment System Inpatient Pricer Program using the following formula: Number of interns and residents divided by available beds; plus 1; to the power of 0.405; minus 1; multiplied by 1.35.

003.03(C) CALCULATION OF MANAGED CARE ORGANIZATION MEDICAL EDUCATION PAYMENTS. Medicaid will calculate annual MCO Direct Medical Education payments and managed care organization indirect medical education payments for

services provided by Medicaid capitated plans from discharge data provided by the managed care organization. Managed care organization direct medical education payments will be equal to the number of managed care organization discharges times the fee-for service direct medical education payment per discharge in effect for the rate year July 1 through June 30. Managed care organization indirect medical education payments will be equal to the number of managed care organization discharges times the managed care organization indirect medical education payment per discharge. The indirect medical education payment per discharge is calculated as follows. Subtotal each teaching hospital's fee-for-service inpatient acute indirect medical education prior year payments. Subtotal each teaching hospital's fee-for-service inpatient covered prior state fiscal year charges. Divide each teaching hospital's indirect medical education payments, by covered prior state fiscal year charges. Multiply this ratio times the covered charges in managed care organization paid claims in the base year. Divide this amount by the number of managed care organization paid claims in the base year.

003.03(D) CALCULATION OF CAPITAL-RELATED COST PAYMENT. Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the diagnosis related group. Capital-related payment per diem amounts effective July 1, 2009 are calculated for Peer Group 1, 2 and 3 hospitals based on the capital-related payment per diem amounts effective during state fiscal year 2007, adjusted for budget neutrality, as follows: Peer Group 1 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 1 Capital-related payment per diem amount of $36.00 by the Stable diagnosis related group budget neutrality factor. Peer Group 2 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 2 Capital-related payment per diem amount of $31.00 by the stable diagnosis related group budget neutrality factor. Peer Group 3 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 3 Capital-related payment per diem amount of $18.00 by the Stable diagnosis related group budget neutrality factor. Capital-Related Payment Per Diem Amounts effective July, 2010 will be reduced by 2.5% effective July 1, 2011. Capital-Related Payment Per Diem Amounts effective July, 2011 will be increased by 1.54% effective July 1, 2012. Capital-Related payment Per Diem Amounts effective July, 2012 will be increased by 2.25% effective July 1, 2013. Capital-Related payment Per Diem Amounts effective July, 2013 will be increased by 2.25% effective July 1, 2014. Capital-Related payment Per Diem amounts effective July 1, 2014 will be increased by 2% effective July 1, 2015. Capital-Related payment Per Diem amounts effective July 1, 2015, will be increased by 2% effective July 1, 2016. Capital-Related payment Per Diem amounts effective July 1, 2016, will be increased by 2% effective July 31, 2019. Capital-Related payment per diem amounts effective July 31, 2019, will be increased by 2% effective July 1, 2020.

003.03(E) TRANSPLANT DIAGNOSIS RELATED GROUP PAYMENTS. Transplant discharges, identified as discharges that are classified to a transplant diagnosis related group, are paid a transplant diagnosis related group cost-to-charge ratio payment and, if applicable, a direct medical education payment. Transplant diagnosis related group discharges do not receive separate cost outlier payments, independent medical examination cost payments or capital-related cost payments.

003.03(E)(i) TRANSPLANT DIAGNOSIS RELATED GROUP COST-TO-CHARGE RATIO PAYMENTS. Transplant diagnosis related group cost-to-charge ratio payments are calculated by multiplying the hospital-specific transplant diagnosis related group cost-to-charge ratio by Medicaid allowed claim charges. Transplant diagnosis related group cost-to-charge ratio are calculated as follows: Extract from the centers for Medicare and Medicaid services prospective payment system Inpatient pricer program for each hospital the Medicare inpatient prospective payment system operating and capital outlier cost to charge effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier cost-to-charge ratio in effect for the Medicare system on October 1, 2008; sum the operating and capital outlier cost-to-charge ratio; multiply the sum of the operating and capital outlier cost-to-charge ratios by the transplant diagnosis related group budget neutrality factor. On July 1 of each year, the Department will update the Transplant diagnosis related group cost-to-charge ratios based on the percentage change in Medicare outlier cost-to-charge ratios effective October 1 of the two previous years, before budget neutrality adjustments. Effective July 1, 2011, the transplant diagnosis related group cost-to-charge ratios will be reduced by 2.5%. Effective July 1, 2012, the transplant diagnosis related group cost-to-charge ratios will be increased by 1.54%. Effective July 1, 2013, the transplant diagnosis related group cost-to-charge ratios will be increased by 2.25%. Effective July 1, 2014, the transplant diagnosis related group cost-to-charge ratios will be increased by 2.25%. Effective July 1, 2015, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 1, 2016, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 31, 2019, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 1, 2020, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%.

003.03(E)(ii) TRANSPLANT DIAGNOSIS RELATED GROUP DIRECT MEDICAL EDUCATION PAYMENTS. Transplant diagnosis related group direct medical education payments are calculated using the same methodology described in subsection this chapter, with the exception that in step 4, direct medical education per discharge payment amounts are adjusted by the transplant diagnosis related group budget neutrality factor. On July 1st of each year, the Department will update transplant direct medical education payment per discharge rates as described in this regulation. On July 1st of each year, the Department will update transplant diagnosis related group direct medical education payment per discharge rates as described in this chapter.

003.03(F) BUDGET NEUTRALITY FACTORS. Peer Group Base Payment Amounts, are multiplied by budget neutrality factors, determined as follows:

003.03(F)(i) DEVELOP FISCAL SIMULATION ANALYSIS. The Department will develop a fiscal simulation analysis using Medicaid inpatient fee-for-service paid claims data from state fiscal year 2011. The fiscal simulation analysis includes discharges grouped into a diagnosis related group and excludes all psychiatric, rehabilitation and transplant discharges. In the fiscal simulation analysis, the Department will apply all rate year payment rates before budget neutrality adjustments to the claims data and simulate payments.

003.03(F)(ii) DETERMINE BUDGET NEUTRALITY FACTORS. The Department will set budget neutrality factors in fiscal simulation analysis such that simulated payments are equal to the claims data reported payments, inflated by Peer Group Base Payment Amount increases approved by the Department from the end of the claims data period to the rate year. For rates effective July 1, 2014, the Department will inflate the state fiscal year 2011 base rates by 61.05%.

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

003.03(G)(i) RECONCILIATION TO FACILITY UPPER PAYMENT LIMIT. Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A reconciliation will be made within 6 months following receipt by the Department of the facilities settled cost report. Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110% of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

003.03(H) TRANSFERS. When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary. For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full diagnosis related group payment. The average daily rate is calculated as the full diagnosis related group payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related diagnosis related group. For hospitals receiving a transferred patient, payment is the full diagnosis related group payment and, if applicable, cost outlier payment.

003.03(I) INPATIENT ADMISSION AFTER OUTPATIENT SERVICES. A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a patient is admitted as an inpatient within three calendar days of the day that the hospital

outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

003.03(J) READMISSIONS. Medicaid adopts Medicare peer review organization regulations to control increased admissions or reduced services. All Medicaid patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

003.03(K) INTERIM PAYMENT FOR LONG-STAY PATIENTS. Medicaid's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days. To request an interim payment, the hospital shall send a completed Form HCFA-1450, UB-92, for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to the Department of Health and Human Services Finance and Support. The hospital will be notified in writing if the request for interim payment is denied.

003.03(K)(i) FINAL PAYMENT FOR LONG-STAY PATIENT. When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement from and to dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

003.03(L) PAYMENT FOR NON-PHYSICIAN ANESTHETIST FEES. Hospitals which meet the Medicare exception for payment of certified registered nurse anesthetist fees as a pass-through by Medicare will be paid for certified registered nurse anesthetist fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for certified registered nurse anesthetist services. Costs will be calculated using the hospital's specific anesthesia cost-to-charge ratio. Certified registered nurse anesthetist fees must be billed using revenue code 964 - Professional Fees Anesthetist on the HCFA-1450, UB-92, claim form.

004. NON-PAYMENT FOR HOSPITAL ACQUIRED CONDITIONS. Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that Medicaid will, at a minimum, identify as a hospital acquired condition, those secondary diagnosis codes that have been identified as Medicare hospital acquired conditions when not present on hospital admission.

005. PAYMENTS FOR PSYCHIATRIC SERVICES. Payments for psychiatric discharges are made on a prospective per diem. Tiered rates will be used for all acute psychiatric inpatient services. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier. Payment is made for the day of admission, but not the day of discharge. For payment of inpatient hospital psychiatric services, effective July 1, 2014, the tiered per diem rate will be: $715.32 for 1 and 2 days of service; $661.55 for 3 and 4 days of service; $631.18 for 5 and 6 days of service; and $601.14 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2015, the tiered per diem rate will be: $731.41 for 1 and 2 days of service; $676.43 for 3 and 4 days of service; $645.38 for 5 and 6 days of service; and $614.67 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2016, the tiered per diem rate will be: $747.87 for 1 and 2 days of service; $691.65 for 3 and 4 days of service; $659.90 for 5 and 6 days of service; and $628.50 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 31, 2019, the tiered per diem rate will be: $777.79 for 1 and 2 days of service; $719.32 for 3 and 4 days of service; $686.30 for 5 and 6 days of service; and $653.64 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2020, the tiered per diem rate will be: $809.00 for 1 and 2 days of service; $748.00 for 3 and 4 days of service; $714.00 for 5 and 6 days of service; and $680.00 for 7 and 8 days of service.

005.01 PAYMENT FOR PSYCHIATRIC ADULT INPATIENT SUBACUTE HOSPITAL SERVICES. Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. This rate may be reviewed annually. Effective April 12, 2008, the payment for psychiatric adult subacute inpatient hospital services identified in state regulations was $488.13. Beginning July 1, 2008, the per diem rate was $505.21 and on November 24, 2009 onward the rate is $512.79. On July 1, 2010, there will be a .5% rate increase. On July 1, 2011, there will be a 2.5% rate decrease. On July 1, 2012 there is a 1.54% increase. On July 1, 2013, there will be a 2.25% rate increase. On July 1, 2014, there will be a 2.25% rate increase. On July 1, 2015, there will be a 2.25% rate increase. On July 1, 2016, there will be a 2.25% rate increase. On July 31, 2019, there will be a 4% rate increase. On July 1, 2020, there will be a 4% rate increase. The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all-inclusive per diem, with the exception of physician services.

006. PAYMENTS FOR REHABILITATION SERVICES. Payments for rehabilitation discharges are made on a prospective per diem. All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of: the hospital-specific base payment per diem rate; the hospital-specific capital per diem rate; and the hospital's direct medical education per diem rate, if applicable. Payment for each discharge equals the per diem times the number of approved patient days. Payment is made for the day of admission but not for the day of discharge.

006.01 ADJUSTMENT OF HOSPITAL-SPECIFIC BASE PAYMENT AMOUNT. The hospital-specific per diem rates will be increased by .5% for the rate period beginning July 1, 2010. Effective July 1, 2011, the transplant diagnosis related group direct medical education rates will be reduced by 2.5%. Effective July 1, 2012, the transplant diagnosis related group direct

medical education rates will be increased by 1.54%. Effective July 1, 2013, the transplant diagnosis related group direct medical education rates will be increased by 2.25%. Effective July 1, 2014, the transplant diagnosis related group direct medical education rates will be increased by 2.25%. Effective July 1, 2015, the transplant diagnosis related group direct medical education rates will be increased by 2%. Effective July 1, 2016, the transplant diagnosis related group direct medical education rates will be increased by 2%. Effective July 31, 2019, the transplant diagnosis related group direct medical education rates will be increased by 2%. Effective July 1, 2020, the transplant diagnosis related group direct medical education rates will be increased by 2%.

006.02 CALCULATION OF HOSPITAL-SPECIFIC CAPITAL PER DIEM RATE. Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem as described in this chapter.

007. PAYMENT FOR SERVICES FURNISHED BY A CRITICAL ACCESS HOSPITAL. Effective for cost reporting periods beginning July 1, 2015, and after payment for inpatient services of a critical access hospital is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges rule, ceilings on hospital operating costs, and the reasonable compensation equivalent limits for physician services to providers. Subject to the 96-hour average on inpatient stays in critical access hospitals, items and services that a critical access hospital provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

008. RATES FOR STATE-OPERATED INSTITUTIONS OF MENTAL DISEASE. Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated institutions of mental diseases will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

009. DISPROPORTIONATE SHARE HOSPITALS. A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

(A) The names of at two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for Medicaid. This requirement does not apply to a hospital:
  (i) The inpatients of which are predominantly individuals under 18 years of age;
  (ii) Which does not offer non-emergency obstetric services to the general population as of December 21, 1987; or
  (iii) For a hospital located in a rural area, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures;

(B) Only Nebraska hospitals which have a current enrollment with Medicaid will be considered for eligibility as a disproportionate share hospital; and

(C) When notified by the Department that the hospital qualifies as a disproportionate share hospital, each hospital must certify to Medicaid that it has incurred costs for the delivery of uncompensated care which are equal to or exceed the amount of the disproportionate share hospital payment.

009.01 DISPROPORTIONATE SHARE ELIGIBILITY CALCULATION. To calculate eligibility, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a disproportionate share hospital will be calculated using the following data.

009.01(A) MEDICAID INPATIENT UTILIZATION RATE. To determine the Medicaid inpatient utilization rate, the denominator will be the total days as reported on the Medicare cost report. The numerator will be the sum of each hospital's Medicaid days, which includes the Medicaid management information system claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made. Only secondary payor days in the Medicaid management information system claims file data will be included.

009.02(B) LOW INCOME UTILIZATION RATE. To determine the low-income utilization rate, data from the Nebraska accounting system will be used to calculate the low-income utilization rate for state-owned institutions for mental disease. For all other hospitals, the hospital's certified report of total revenue, Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

009.02 DISPROPORTIONATE SHARE HOSPITAL UPPER PAYMENT LIMIT AND UNCOMPENSATED CARE CALCULATION. The Disproportionate Share Hospital upper payment limit and the uncompensated care calculation is the sum of the Medicaid shortfall plus the cost of uninsured care.

(A) The Department will calculate the Medicaid shortfall as follows:
  (i) The Department will determine the costs of Medicaid fee-for-service and managed care inpatient services by:
    (1) Calculating a hospital's routine cost per day for each cost center from the Centers for Medicare and Medicaid Services 2552 cost report by dividing the total costs by the total days; and
    (2) Multiplying the cost per day times the number of Medicaid allowable days provided during the same fiscal year as the filed cost report, and paid up to 150 days after the end of the fiscal year.
  (ii) The Department will determine costs of Medicaid fee-for-service and managed care outpatient services by:
    (1) Calculating a hospital's ancillary cost-to-charge ratio from the Centers for Medicare and Medicaid Services 2552 cost report; and
    (2) Multiplying the total Medicaid allowable charges times the ancillary cost-to-charge ratio.
  (iii) The total Medicaid cost is the sum of the inpatient and outpatient costs for each hospital; and
  (iv) The Medicaid shortfall is determined by subtracting the total allowable Medicaid payments from the total Medicaid cost.
(B) The Department will calculate the cost of uninsured care by using each hospital's charges for services provided to uninsured patients as filed and certified to the Department for the same fiscal year as the Centers for Medicare and Medicaid Services cost report used in determining costs. The Department will convert each hospital's charges to cost for uninsured patients by multiplying the charges by the

overall cost-to-charge ratio determined using each hospital's Centers for Medicare and Medicaid Services 2552 report for the same fiscal year used in determining cost; and

(C) The Medicaid upper payment limit and the uncompensated care amount shall be the sum of the Medicaid shortfall plus the cost of uninsured care.

009.03 DISPROPORTIONATE SHARE PAYMENTS. Disproportionate share payments will be made each federal fiscal year following receipt of all required data by the Department. The total of all disproportionate share payments must not exceed the limits on disproportionate share hospital funding as established for this State by the Centers for Medicare and Medicaid Services in accordance with the provisions of the Social Security Act, Title XIX, Section 1923. Payments determined for each federal fiscal year will be considered payment for that year, and not for the year from which proxy data used in the calculation was taken. To calculate payment, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination will be applied.

009.03(A) METHODS. For federal fiscal year 2007 and succeeding years, the Department will make a disproportionate share hospital payment to hospitals that qualify for a payment under one of the following pool distribution methods.

009.03(A)(i) BASIC DISPROPORTIONATE SHARE PAYMENT POOL 1. Pool 1 consists of eligible hospitals in peer groups 2, 3, and 6 that are not eligible under pool 6.

009.03(A)(i)(1) POOL 1. Total funding to Pool 1 will be $1,000,000. In federal fiscal year 2008 and following years, this amount will be increased by the percentage change in the consumer price index for all urban consumers, all items; U.S. city average. The Department will calculate the payment as follows. First, each hospital's Medicaid days, which include days from the Medicaid management information system claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made, will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in pool 1. Second, the ratio resulting from such division will be multiplied times the total funding for pool 1 to determine each hospital's payment. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under section 1923(f) of the Social Security Act, the payment will be reduced. If payment is reduced to a hospital within pool 1, the additional funds will be redistributed pro rata to eligible hospitals within pool 1.

009.03(A)(i)(2) BASIC DISPROPORTIONATE SHARE PAYMENT POOL 2. Pool 2 consists of eligible hospitals in Peer Groups 1, 2, and 3 that are also eligible under Pool 6.

009.03(A)(i)(2)(a) POOL 2. Total funding to pool 2 will be $3,154,000 for federal fiscal year 2007, and $2,654,000 for federal fiscal year 2008. For federal fiscal year 2009 and following years, the total funding will be the amount

for federal fiscal year 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers, all items; U.S. city average. The Department will calculate the payment for pool 2 as follows. First, each hospital's Medicaid days, which include days from the Medicaid management information system claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made, will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in pool 2. Second, the ratio resulting from the division will be multiplied times the total funding for Pool 2 to determine each hospital's payment. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced. If payment is reduced to a hospital within pool 2, the additional funds will be redistributed pro rata to eligible hospitals within pool 2.

009.03(A)(i)(3) DISPROPORTIONATE SHARE PAYMENT FOR HOSPITALS THAT PRIMARILY SERVE CHILDREN POOL 3. Pool 3 consists of the hospital that both primarily serves children age 20 and under, and has the greatest number of Medicaid days.

009.03(A)(i)(3)(a) POOL 3 FUNDING. Total funding for pool 3 will be $3,138,000 for federal fiscal year 2007, and $3,638,000 for federal fiscal year 2008. For federal fiscal year 2009 and following years, the total funding will be the amount for federal fiscal year 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers, all items; U.S. city average. A hospital eligible for payment under this pool will not be eligible for payment under any other pool. If payment to the hospital exceeds the disproportionate share hospital payment limit, as established under 1923(f) of the Social Security Act, the payment will be reduced.

009.03(A)(i)(4) DISPROPORTIONATE SHARE PAYMENT FOR STATE OWNED INSTITUTIONS FOR MENTAL DISEASE HOSPITALS AND FOR ELIGIBLE HOSPITALS IN PEER GROUP 4 POOL 4. Pool 4 consists of state owned institutions for mental disease and other eligible hospitals in peer group 4.

009.03(A)(i)(4)(a) POOL 4 FUNDING. Total funding for Pool 4 will be $1,811,337 annually. The Department will calculate payments as follows. Each eligible hospitals must certify in writing to the Nebraska Medical Assistance Program its charges for uncompensated care for the hospital's fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospitals cost-to-charge ratio. Payment to each hospital will be equal to the cost of its uncompensated care. If the total of all disproportionate share payment amounts for pool 4 exceeds the federally determined disproportionate share hospital limit for Nebraska, the will be reduced pro rata.

009.03(A)(i)(5) NON-PROFIT ACUTE CARE TEACHING HOSPITAL AFFILIATED WITH A STATE-OWNED UNIVERSITY MEDICAL COLLEGE POOL 5. Pool 5 consists of the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this pool may be eligible for payment under Pool 6.

009.03(A)(i)(5)(a) POOL 5 FUNDING. Total funding to Pool 5 will be $15,000,000. For FFY 08 and following years the funding will be increased annually by the percentage change in the consumer price index for all urban consumers, all items; U.S. city average. The Department will calculate the disproportionate share hospital payment to Pool 4 5 as an amount equal to the cost of its uncompensated care. If the payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(f) of the Social Security Act, the payment will be reduced.

009.03(A)(i)(6) UNCOMPENSATED CARE POOL. Pool 6 consists of hospitals that provide services to low-income persons covered by a county administered general assistance program; or hospitals that provide services to low-income persons covered by the state administered public behavioral health system.

009.03(A)(i)(6)(a) POOL 6 FUNDING. Total funding to Pool 6 will be the remaining balance of the total, federal and state, disproportional share hospital funding minus the funding for pools 1, 2, 3, 4, and 5, The Department will calculate payments as follows. Disproportionate share hospital payments to a hospital under all other pools will be subtracted from the hospital's disproportionate share hospital upper payment limit before allocating payments under pool 6. The costs for uncompensated care resulting from participation in county administered general assistance program will be reported by the county; and costs for the state administered public behavioral health system will be reported by each hospital. Reported costs will be subject to audit by the Department. A ratio for each hospital will be determined based on the uncompensated cost for each hospital to the total of uncompensated cost for all hospitals in pool 6. The ratio for each hospital will be multiplied times the available funding to the Pool to yield each hospital' annual payment amount. The total computable payment will be commensurate with the charges for uncompensated care resulting from participation in county administered general assistance program; or the state administered public behavioral health system. The annual payment amount will be dispersed in twelve monthly payments. If payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(g) of the Social Security Act, the payment will be reduced to the payment limit. If payments to hospitals under this pool exceed the total allotment to Nebraska, the payments will be reduced pro rata.

009.03(B) LIMITATIONS ON DISPROPORTIONATE SHARE PAYMENTS. No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923(g)(1)(A) of the Social Security Act. Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act.

009.04 REDISTRIBUTION OF DISPROPORTIONATE SHARE HOSPITAL OVERPAYMENTS. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Department will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009. Beginning in disproportionate share hospital state plan rate year 2011, if the results of audits conducted in accordance with the disproportionate share hospital final rule indicate that a hospital has exceeded the hospital specific disproportionate share hospital limit the amount of disproportionate share hospital payment in excess of uncompensated care costs will be recouped. Any funds recouped shall first be recouped from pool 1 through 5 payments and then from pool 6 payments and shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific disproportionate share hospital limit. Funds recouped from pools 1 through 6 shall first be redistributed to each eligible hospital in the pool in which the hospital payment was recouped. Any recouped funds that are not able to be distributed within the pool will accumulate and be redistributed to all eligible hospitals.

009.04(A) CALCULATION. The Department will calculate the redistribution as follows. First, for each pool in which funds were recouped beginning with Pool 1 and proceeding in pool numerical order, each hospital's difference between their disproportionate share hospital payment and disproportionate share hospital limit will be calculated. The difference will be divided by the sum of the difference between the disproportionate share hospital payment and disproportionate share hospital limit for all hospitals in the pool. Second, the ratio resulting from such division will be multiplied times the total funding recouped for the pool to determine each hospital's redistribution payment. If the sum of the original disproportionate share hospital payment and redistribution payment exceeds the disproportionate share hospital payment limit, the payment will be reduced. If payment is reduced to a hospital within a pool, the additional funds will be redistributed pro rata to eligible hospitals within the pool. If all hospitals within the Pool have reached their disproportionate share hospital limit, the remaining funds will be carried forward to be redistributed to all eligible hospitals. For pool 6, each hospital's difference between their disproportionate share hospital payment and disproportionate share hospital limit will include funds redistributed from pools 1 through 5 above.

009.04(B) FINAL REDISTRIBUTION. The final redistribution will be calculated as follows. First, for any funds that were not redistributed for each pool in which funds were recouped, each hospitals, except for pool 4 institutions of mental disease difference between their disproportionate share hospitals payment and disproportionate share hospitals limit will be calculated. The difference will be divided by the sum of the difference between the disproportionate share hospitals payment and disproportionate share hospitals limit for all non-institutions of mental disease hospitals. Second, the ratio resulting from such division will be multiplied times the total recouped funding not already distributed to determine

each hospital's redistribution payment. If the sum of the original disproportionate share hospital payment and redistribution payment exceeds the disproportionate share hospitals payment limit, the payment will be reduced. If payment is reduced to a hospital, the additional funds will be redistributed pro rata to eligible non-institutions of mental disease hospitals within the pool. If all non-institutions of mental disease hospitals have reached their disproportionate share hospital limit, the federal portion of remaining funds will be returned to the Centers for Medicare and Medicaid Services.

010. OUT-OF-STATE HOSPITAL RATES. The Department pays out-of-state hospitals for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals. The peer groups are: metro acute care hospitals, hospitals located in a metropolitan statistical area as designated by Medicare; rural acute care hospitals, all other acute care hospitals; psychiatric hospitals and distinct part units in acute care hospitals, hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in this chapter; and rehabilitation hospitals and distinct part units in acute care hospitals, hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in this chapter. Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. Effective September 1, 2003, capital costs will be calculated as 96.85% of the peer group weighted median cost per day. The cost-to-charge ratio is the peer group average. Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. The Department may allow payments to out-of-state hospitals for direct or indirect medical education costs at a negotiated per discharge rate.

010.01 EXCEPTION. The Administrator of the Medicaid Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in this chapter only when the Medical Director of the Department has determined that:

(A) The client requires specialized services that are not available in Nebraska; and

(B) No other source of the specialized services can be found to provide the services at the rate established in this chapter.

011. OUT-OF-PLAN SERVICES. When enrollees in the Nebraska Health Connection are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are authorized, but are not required, to pay providers of hospital inpatient services who care for individuals enrolled in the Nebraska Health Connection at rates the Department would otherwise reimburse providers under this chapter.

011. FREE-STANDING PSYCHIATRIC HOSPITALS. When a free-standing psychiatric hospital, in Nebraska or out of state, does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service shall bill Medicaid for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. The hospital's rate is calculated according to this chapter. This is an exception to policies related to the elimination of combined billing in this chapter.

012. RATE-SETTING FOLLOWING A CHANGE IN OWNERSHIP. The rate-setting process for facilities with a change in ownership will be the same as the rate-setting process used prior to the change in ownership as described in these regulations.

013. RATE-SETTING FOLLOWING A HOSPITAL MERGER. Hospitals that have combined into a single entity shall be assigned a single combined weighted average for each of the following: direct medical education amount, if applicable, indirect medical education amount, if applicable, cost-to-charge ratio, outpatient percentage, capital amount, and any other applicable rates or add-ons. The weights shall equal each hospital's base year Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the current fiscal year rates which were calculated for each hospital.

014. RATE-SETTING FOR A NEW OPERATIONAL FACILITY. The Department shall establish a prospective per discharge rate for a new operational facility for Peer Groups 1-5. The rate will be the average peer group rate for the respective peer group for the new facility. For critical access hospitals, the rate will be determined individually for each hospital based on reasonable cost. The peer groups are: Metro acute care hospitals, hospitals located in a metropolitan statistical area as designated by Medicare; Other urban acute care hospitals, hospitals that have been redesignated to an metropolitan statistical area by Medicare for federal fiscal year 1995 or 1996 or hospitals designated by Medicare as a regional rural referral center; rural acute care hospitals, all other acute care hospitals with 30 or more base year Medicaid discharges; Psychiatric Hospitals and distinct part units in acute care hospitals, hospitals that are licensed as psychiatric hospitals by the Department and distinct parts as defined in these regulations; Rehabilitation hospitals and distinct part units in acute care hospitals, hospitals that are licensed as rehabilitation hospitals by the Department and distinct parts as defined in these regulations; and critical access hospital, hospitals that are certified as critical access hospitals by Medicare.

015. DEPRECIATION. The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

016. RECAPTURE OF DEPRECIATION. A hospital which is sold for a profit and has received Medicaid payments for depreciation, shall refund to the Department the lower of: the amount of depreciation allowed and paid by the Department; or the product of the ratio of Medicaid allowed inpatient days to total inpatient days; and the amount of gain on the sale as determined by the Medicare intermediary. The year or years for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.

017. ADJUSTMENT TO RATE. Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital shall refund the overpayment amount as determined by the Department to the Department. If the rate adjustment results in increasing a hospital's rate, the Department shall reimburse the underpayment amount as determined by the Department to the hospital.

018. LOWER LEVELS OF CARE. When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. When a Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process, the Department may pay for the pre-admission screening process days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. The hospital shall request prior authorization from the Medicaid Division before the pre-admission screening process days are provided. The Medicaid Division will send the authorization to the hospital. The hospital shall bill for class of care 81 and enter the prior authorization document number from Form MC-9 on Form HCFA-1450 (UB-92). The claim for the pre-admission screening process days must be separate from the claim for the inpatient days paid at the acute rate. The pre-admission screening process days will be disallowed as acute care days and Medicaid will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the pre-admission screening process day. Pre-admission screening process days will not be considered in computing the hospital's prospective rate.

019. ACCESS TO RECORDS. Hospitals shall make all records relating to the care of Medicaid patients and any and all other cost information available to the Department, its designated representatives or agents, or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours. Hospitals shall allow authorized representatives of the Department of Health and Human Services Finance and Support, the federal Department of Health and Human Services, and state and federal fraud and abuse units to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department. The hospital shall allow the authorized representatives access for the purpose of audit and review at any reasonable time during normal working hours upon written notice by the Department at least one working day before the review and audit.

020. AUDITS. The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

021. PROVIDER APPEALS. A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date according to the procedures in 471 NAC 2. A hospital may also request an adjustment to its rate.

022. REQUEST FOR RATE ADJUSTMENTS. Requests for rate adjustments are subject to the rules contained in this section.

022.01 REQUESTS. Hospitals may submit a request to the Department for an adjustment to their rates for the following:

(A) An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate if the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate;

(B) Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate for extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. Extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. Extraordinary circumstances are limited to:

(i) Changes in routine and ancillary costs, which are limited to:

(1) Intern and resident related medical education costs; and

(2) Establishment of a subspecialty care unit.

(ii) Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.

(C) Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:

(i) One-time occurrence;

(ii) Less than twelve-month duration;

(iii) Could not have been reasonably predicted;

(iv) Not of an insurable nature;

(v) Not covered by federal or state disaster relief; and

(vi) Not a result of malpractice or negligence.

022.02 CACULABLE. In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital. If an adjustment is granted, the peer group rates will not be changed.

022.03 RATE ADJUSTMENT REQUIREMENTS. In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following, changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control; every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee; the rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.

022.04 RATE ADJUSTMENT REQUEST SUBMISSION. Requests for rate adjustments must be submitted in writing to the Division. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, the Department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Department's receipt of the request. Regardless

of the Department's decision, the provider will be afforded the opportunity for a conference if requested for a full explanation of the factors involved and the Department's decision. Following review of the matter, the administrator shall notify the facility of the action to be taken by the Department within 30 days of receipt of the request for review or the date of the conference, except in circumstances where additional information is requested or additional investigation or analysis is determined to be necessary by the Department.

022.05 APPLICABILITY. If rate relief is granted as a result of a rate adjustment request, the relief applies only to the rate year for which the request is submitted, except for corrections of errors in rate determination. If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.

022.06 NO EXCEEDING ACTUAL MEDICAD COST. Under no circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology.