TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 31 SERVICES IN AN INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD)

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

002. DEFINITIONS. The following definitions apply:

002.01 ACTIVE TREATMENT. A continuous treatment plan which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that meet the requirements of 42 Code of Federal Regulations (CFR) 483.440(a).

002.02 ADMISSION DATE. The date the facility determines to admit the client to the facility. The determination must occur within 24 hours of the client's arrival at the facility.

002.03 ALTERNATE LEVELS OF CARE. Non-institutional living arrangements providing less care than a nursing facility (NF) or an intermediate care facility for individuals with developmental disabilities (ICF/DD)) and more care than independent living, such as adult family home, domiciliary facility, residential care facility, group home, center for the developmentally disabled, or other community living situations.

002.04 BED HOLDING. Per diem payment made to an intermediate care facility for individuals with developmental disabilities (ICF/DD) to hold a bed when a client is hospitalized or on therapeutic leave.

002.05 BENEFIT FROM ACTIVE TREATMENT. Demonstrable progress in reducing barriers to less restrictive alternatives.

002.06 CLIENT. An individual who has been determined eligible for the Nebraska Medicaid Program.

002.07 COMMUNITY-BASED DEVELOPMENTAL DISABILITY SERVICES. An array of specialized services, including vocational, pre-vocational, residential, and service coordination, provided outside an institutional setting.

002.08 COMPREHENSIVE FUNCTIONAL ASSESSMENT. A report or a series of reports synthesizing the results of relevant evaluations of the client's abilities and deficits to determine

needs. These reports, or assessments, must be made in the following areas: developmental skills, behavioral skills, social skills, health and nutritional status, and other assessments based on the client's needs.

002.09 DEVELOPMENTAL DISABILITY (DD). Developmental disability means a severe, chronic disability, including an intellectual disability, other than mental illness, which:

(1) Is attributable to a mental or physical impairment unless the impairment is solely attributable to a severe emotional disturbance or persistent mental illness;
(2) Is manifested before the age of twenty-two years;
(3) Is likely to continue indefinitely;
(4) Results in substantial functional limitations in one of each of the following areas of adaptive functioning:
    (i) Conceptual skills, including language, literacy, money, time, number concepts, and self-direction;
    (ii) Social skills, including interpersonal skills, social responsibility, self-esteem, gullibility, wariness, social problem solving, and the ability to follow laws and rules and to avoid being victimized; and
    (iii) Practical skills, including activities of daily living, personal care, occupational skills, healthcare, mobility, and the capacity for independent living; and
(5) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance which are of lifelong or extended duration and are individually planned and coordinated.

002.09(A) INDIVIDUALS NINE AND YOUNGER. An individual from birth through the age of nine years inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the major life activities described in subdivision of this section if the individual, without services and support, has a high probability of meeting those criteria later in life.

002.10 DISCHARGE PLAN. A plan developed by the client's interdisciplinary team (IDT) at the time of admission as part of the individual program plan (IPP), reviewed quarterly and revised as needed, which identifies:

(A) The rationale for the client's current level of care;
(B) The types of services the client would require in a less restrictive alternative; and
(C) A summary of alternatives explored for the client through the Department of Health and Human Services Developmental Disabilities Division, Service Coordination (DDD SC) over the past year as in 42 CFR 456.380.

002.11 DUAL DIAGNOSIS. An individual diagnosed with a developmental disability or related condition along with a mental illness disorder.

002.12 HABILITATIVE TRAINING. Training in new skills and behaviors necessary to facilitate independent functioning.

002.13 INDEPENDENT QIDP (QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL) ASSESSMENT. A functional evaluation to determine the client's present skills with recommendations for training, services, and level of care.

002.14 INDIVIDUAL PROGRAM PLAN (IPP). A document or documents developed by the interdisciplinary team (IDT) which includes services and supports needed by the client.

002.15 INDIVIDUALIZED EDUCATIONAL PLAN (IEP). A written statement for a child with a verified disability that specifies the special education and related services necessary to assure that child a free and appropriate education. The development of the individualized educational plan (IEP) is the responsibility of the school district in which the child is receiving educational services.

002.16 INPATIENT DAYS. The number of days of care covered for inpatient intermediate care facility for individuals with developmental disabilities (ICF/DD) 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 Medicaid reporting purposes, even if the intermediate care facility for individuals with developmental disabilities (ICF/DD) uses a different definition of a day for statistical or other purposes.

002.16(A) PART OF DAY. Except for death on the day of admission, a part of a day on the day of discharge or death is not counted as a day. If inpatient admission and death occur on the same day, the day is considered a day of admission and counted as one inpatient day.

002.17 INTELLECTUAL DISABILITY (ID). An individual with significantly sub-average, general intellectual functioning existing concurrently with deficits in adaptive behavior. An intelligence quotient of seventy or below on a reliably administered intelligence quotient test is presumptive evidence of intellectual disability.

002.18 INTERDISCIPLINARY TEAM (IDT). A group of persons representing the professions, disciplines, or service areas which are relevant to identifying the client's needs, and coordinating and designing training programs and services to meet these needs. Team membership varies according to individual needs, but must always include a qualified intellectual disability professional (QIDP) and a person(s) responsible to assure the client's rights are protected. The interdisciplinary team (IDT) must include the client and the client's legal representative(s).

002.19 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). A facility where shelter, food, and active treatment are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have an Intellectual Disability or related condition.

002.20 LEAST RESTRICTIVE ALTERNATIVE. The most appropriate living environment which meets the client's needs in the most normalizing manner.

002.21 LEVEL OF CARE (LOC). A category of living arrangement. Levels of care funded by Medicaid include nursing facility (NF), intermediate care facility for individuals with developmental disabilities (ICF/DD), acute hospital, and institution for mental disease (IMD).

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

002.23 MEDICAL CARE PLAN. A plan developed by the physician when the physician determines the client requires 24-hour nursing care or the client suffers from an acute illness requiring 24-hour nursing care.

002.24 MENTAL ILLNESS. A mental disorder according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

002.25 NEED LEVEL. A classification system which identifies clients as high need, moderate need, or low need, which is:

(A) Based on the amount of staff time required to meet the client's needs; and
(B) Determined by intermediate care facility for individuals with developmental disabilities (ICF/DD) staff.

002.26 NURSING FACILITY (NF). A facility, or a distinct part of a facility, as defined in, and operating in, accordance with 471 Nebraska Administrative Code (NAC) 12.

002.27 PHYSICIAN'S CERTIFICATION. Physician's determination specifying the type of services the client requires.

002.28 PLAN OF CARE. A plan to provide care and interventions to a person according to that person's needs.

002.29 PRE-ADMISSION EVALUATION. An interdisciplinary process to determine:

(1) Specific needs of the client;
(2) The least restrictive alternative which meets the client's needs;
(3) Availability of the least restrictive alternative;
(4) The intermediate care facility for individuals with developmental disabilities (ICF/DD)'s ability to meet the client's needs; and
(5) If admitted, a written plan of services for the first 30 days.

002.29(A) ADMISSION DECISION. This process results in the intermediate care facility for individuals with developmental disabilities (ICF/DD)'s decision on admitting the client.

002.30 POST-ADMISSION EVALUATION. The initial Individual program plan developed and implemented by the interdisciplinary team within 30 days of the client's admission to the facility. The post-admission evaluation is based on the results and recommendations of the functional assessments completed during the client's initial 30 days residing at the facility.

002.31 PRIOR AUTHORIZATION. Determination of necessity for intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care and authorization for payment.

002.33 QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL (QIDP). A member of the client's interdisciplinary team who is responsible for coordinating and monitoring the client's active treatment program. The qualified intellectual disabilities professional (QIDP) must meet the federal qualifications found at 42 CFR 483.430(a) through 483.430(a)(2)(iii) and 42 CFR 483.430(b)(5) through 483.430(b)(5)(x).

002.34 RELATED CONDITION. A severe, chronic disability which meets the following conditions:

- (A) It is attributable to:
  - (i) Cerebral palsy or epilepsy; or
  - (ii) Any other condition, other than 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) In the case of a child under three years of age, results in at least one developmental delay;
- (E) In the case of a person three years of age or older, 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; and
- (F) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are life-long or of an extended duration and are individually planned and coordinated.

002.35 SUBSTANTIAL FUNCTIONAL LIMITATION. A demonstrated interference in the capacity or ability to perform activities appropriate given the individual's stage of development.

002.36 THERAPEUTIC LEAVE. Therapeutically indicated overnight home visits with relatives and friends or visits to participate in therapeutic or habilitative programs.

002.37 UTILIZATION REVIEW. Review of Medicaid-eligible clients residing in intermediate care facility for individuals with developmental disabilities (ICF/DD) facilities to determine the client's need for intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in the Nebraska Medical Assistance Program (Medicaid), providers of intermediate care facility for individuals with developmental disabilities (ICF/DD) services must comply with all applicable participation requirements codified in 471 NAC 2 and 3. In the event which provider participation

requirements in 471 NAC 2 and 3 conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter govern.

003.02 SPECIFIC PROVIDER REQUIREMENTS. To participate in Medicaid, an intermediate care facility for individuals with developmental disabilities (ICF/DD) must:
(1) Meet all related requirements for participation in Medicaid as required by state and federal law and regulation;
(2) Be certified as a Title XIX intermediate care facility for individuals with intellectual disabilities (ICF/IID) per federal regulations and licensed as an intermediate care facility for individuals with developmental disabilities (ICF/DD) by the Nebraska Department of Health and Human Services, Division of Public Health or, for an out-of-state facility, by that state's survey agency;
(3) Provide licensed nurses sufficient to care for clients' health needs, as defined in 42 CFR 483.460(c) and (d);
(4) Provide active treatment as defined in this chapter, and 42 CFR 483.440 - 483.450; and
(5) Have a current Medicaid provider agreement with the Department of Health and Human Services, Division of Medicaid and Long-Term Care.

003.02(A) AGENCY COOPERATION. All intermediate care facility for individuals with developmental disabilities (ICF/DD) facilities must provide staff of the federal Department of Health and Human Services, and Medicaid with the data, forms, and cooperation necessary to admit, plan for, evaluate the needs of, and make determinations on the appropriate care level for each individual eligible for Medicaid as required by federal and state Medicaid regulations.

003.02(B) FREEDOM OF CHOICE. Each intermediate care facility for individuals with developmental disabilities (ICF/DD) must ensure that any client may exercise their freedom of choice in obtaining Medicaid-covered services from any provider qualified to perform the services.

003.02(C) ROOM AND BED ASSIGNMENTS. The facility must ensure any changes made in the client's room or bed assignment is documented in the client's individual program plan (IPP). This record must show the dates and reasons for all changes in accordance with 42 CFR 442.404.

003.02(D) DISCHARGE. The intermediate care facility for individuals with developmental disabilities (ICF/DD) must ensure any client identified to permanently move from the facility is discharged according to requirements in this section. If the client moves to a separately licensed and certified intermediate care facility for individuals with developmental disabilities (ICF/DD), the same discharge requirements must be followed. The client must be admitted to the receiving intermediate care facility for individuals with developmental disabilities (ICF/DD).

003.02(D)(i) DISCHARGE PLANNING. The intermediate care facility for individuals with developmental disabilities (ICF/DD) must include discharge planning procedures for all Nebraska Medicaid clients in the individual program plan (IPP). The discharge

planning procedures must be reviewed and updated (if needed) by the client's interdisciplinary team (IDT) at least annually. The procedures must include:
(1) Which intermediate care facility for individuals with developmental disabilities (ICF/DD) staff person is responsible for discharge planning; and
(2) The interdisciplinary team (IDT)'s determination of the level of care the client needs or may need upon discharge, including programming, medical, nutritional, psychological or psychiatric, and supervision needs.

003.02(D)(ii) DISCHARGE TO ALTERNATIVE SETTING. If it is determined that a client does not meet level of care requirements and the client's health and habilitative needs could more appropriately be met in another setting, the facility must follow the steps as outlined in this chapter.

003.02(D)(iii) DISCHARGE PROCESS. When a client is to be discharged, the intermediate care facility for individuals with developmental disabilities (ICF/DD) facility must ensure:
(a) The following is documented in the client's individual program plan (IPP):
  (i) Notification of the discharge to the client as well as to the family or legal representative;
  (ii) The justification for the discharge;
  (iii) The type of service or level of care the client is being discharged to;
  (iv) The date the client is discharged; and
  (v) The discharge plan which must include activities to ensure the client is adequately prepared for the discharge and the receiving facility is provided current information related to the client's social and programming history, current developmental skills and skill deficits, current training needs, and medical, nursing and nutritional status;
(b) All adaptive equipment and supplies specifically purchased for the client move with the client; and
(c) Medicaid is notified of the discharge within 10 days of discharge, to include the type of service setting the client was discharged to.

003.02(D)(iii)(1) NOTICE. Should the client's interdisciplinary team (IDT) decide to discharge the client without plans to admit to another service provider, the facility must notify the Department of Health and Human Services' Developmental Disabilities Division, Service Coordination (DDD SC) within two working days of the interdisciplinary team (IDT)'s decision in order to aid the client and their legal representative to secure alternative services.

003.02(D)(iv) CLIENT DEATH. Within 10 days after a client has expired, the intermediate care facility for individuals with developmental disabilities (ICF/DD) must notify Medicaid of the date of death.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

004.01(A) MEDICAL NECESSITY. Intermediate care facility for individuals with developmental disabilities (ICF/DD) services must meet the medical necessity requirements in 471 NAC 1, and each client must be determined to meet level of care criteria outlined in this chapter.

004.01(B) PRIOR AUTHORIZATION. Medicaid pays for intermediate care facility for individuals with developmental disabilities (ICF/DD) services only when prior authorized. Each admission must be separately prior authorized.

004.01(C) ADMISSION PROCESS. For all clients seeking Medicaid payment for intermediate care facility for individuals with developmental disabilities (ICF/DD) services, the facility must complete a pre-admission evaluation to determine if the client is Medicaid eligible or has applied for Medicaid, has been diagnosed with an intellectual disability or related condition and whether the facility can provide services to meet the client's needs. In addition, the facility must determine that the client needs and will benefit from active treatment. The facility must conduct or obtain the following as part of the pre-admission evaluation:

(1) Current and comprehensive physician's examination;
(2) A current dental examination completed within 12 months before admission or within one month after the date of admission;
(3) Current and comprehensive functional assessments conducted on the day of and no more than three months prior to the admission;
(4) Psychological evaluation which includes the client's diagnoses, must be completed on or no more than three months prior to admission;
(5) The most recent individual program plan and if school age, the most recent individual education plan. Must have been implemented within the previous twelve months;
(6) Current, within the previous twelve months, habilitative training records;
(7) Current medical records;
(8) Physician certification for the client's need of intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care. Must be signed by the physician;
(9) Physician plan of care, as required by 42 CFR 456.380; and
(10) Independent qualified intellectual disabilities professional (QIDP) assessment.

004.01(C)(i) EVALUATIONS. Evaluations conducted must meet requirements found at 42 CFR 456.370(c). All evaluations, assessments, and records obtained must be current with the client's needs at the time of the admission process as required at 42 CFR 456.370(a) and (b).

004.01(C)(ii) ADMISSION DETERMINATION. The facility will review the pre-admission evaluation and hold a pre-admission meeting with the client, guardian, and interdisciplinary team (IDT) to determine admission. Personnel from outside the facility that previously provided services to the client should be encouraged to attend, as well. The purpose of the pre-admission meeting is to:

(a) Summarize in writing the findings from the individual functional assessments;

(b) Determine the client's needs without regard to the intermediate care facility for individuals with developmental disabilities (ICF/DD)'s ability to meet those needs;
(c) Determine whether or not the intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care is appropriate and meets the client's needs. If the interdisciplinary team (IDT) determines that intermediate care facility for individuals with developmental disabilities (ICF/DD) services are not appropriate to meet the client's needs, the intermediate care facility for individuals with developmental disabilities (ICF/DD) must refer the client and legal guardian to the Department of Health and Human Services' Developmental Disabilities Division, Service Coordination (DDD SC) to determine the availability of alternative services;
(d) Determine if the client will be admitted to the intermediate care facility for individuals with developmental disabilities (ICF/DD); and
(e) Develop the pre-admission plan if the client is to be admitted.

004.01(C)(ii)(1) ALTERNATIVES. The intermediate care facility for individuals with developmental disabilities (ICF/DD), Medicaid, the client, family, guardian, attending physician, and intermediate care facility for individuals with developmental disabilities (ICF/DD)'s interdisciplinary team (IDT) staff must cooperatively explore alternatives available through Medicaid programs based on the client's total needs.

004.01(C)(iii) PRE-ADMISSION PLAN. The pre-admission plan is the individual program plan (IPP) for the first 30 days after the client is admitted to the intermediate care facility for individuals with developmental disabilities (ICF/DD). The plan must:
(1) Include the client's name, date of birth, and guardianship status;
(2) Document the interdisciplinary team (IDT)'s rationale for admitting the client;
(3) Identify additional needed evaluations;
(4) Identify the client's skills and skill deficits;
(5) Identify baselines which are conducted to determine training needs;
(6) Identify the client's current medical and nutritional status;
(7) Specify the care, services, and referral for additional evaluations to be provided for the first 30 days or until the post-admission evaluation is established;
(8) Include programs and services to be continued from other programs; and
(9) Include a plan to explore alternative, less restrictive services on an ongoing basis.

004.01(C)(iv) PHYSICIAN'S ADMISSION HISTORY AND PHYSICAL. When the client is admitted to the intermediate care facility for individuals with developmental disabilities (ICF/DD), the facility must ensure that:
(1) The client has a physical examination within 48 hours, two working days, after admission, unless an examination was performed within thirty days before admission; and
(2) The history and physical is documented on Form DM-5 or attached to Form DM-5.

004.01(C)(v) PHYSICIAN'S INITIAL CERTIFICATION (FORM DM-5 OR FORM MC-9NF). The physician's certification on Form DM-5, Form MC-9NF, or Nursing Facility Level Of Care Determination Form, must be signed within the following time frame:

(a) For clients already eligible for Medicaid at the time of admission, Form DM-5, Form MC-9NF, or Nursing Facility Level Of Care Determination Form must be signed and dated within 30 days before the date of admission, or within 48 hours (two working days) after the date of admission; or
(b) For clients not already determined to be eligible for Medicaid at the time of admission, Form DM-5, Form MC-9NF or Nursing Facility Level Of Care Determination Form must be signed and dated within 30 days before or within 48 hours (two working days) after the date the client's eligibility is determined.

004.01(C)(v)(1) ELIGIBILITY DETERMINATION. The date of eligibility for intermediate care facility for individuals with developmental disabilities (ICF/DD) services is defined as the actual date the eligibility determination is made not necessarily the effective date of Medicaid eligibility. The following circumstances impact Medicaid coverage of intermediate care facility for individuals with developmental disabilities (ICF/DD) services:

(a) If Form DM-5, Form MC-9NF, or Nursing Facility Level of Care Determination Form, is signed and dated more than 30 days before the date of eligibility determination, the facility must provide Medicaid with a new or updated Form DM-5, Form MC-9NF, or Nursing Facility Level of Care Determination Form before Medicaid authorizes payment to the facility;
(b) If Form DM-5, Form MC-9NF, or the Nursing Facility Level of Care Determination Form is signed and dated more than 48 hours two working days after admission or eligibility determination, the earliest that payment to the facility could be effective is the date Form DM-5, Form MC-9NF, or the Nursing Facility Level Of Care Determination Form, is signed and dated. Holidays and weekends are not counted if they fall within the 48-hour time period; and
(c) If the date of Form DM-5, Form MC-9NF, or the Nursing Facility Level of Care Determination Form falls within the required time frame, Medicaid may authorize payment to be effective on the date of admission or the medical eligibility effective date.

004.01(C)(v)(2) SIGNATURE REQUIREMENTS. Form DM-5 must be signed and dated by a physician, if a physician signature stamp is used, the physician must initial the stamped signature. Physician's assistant or registered nurse signature or initials are not acceptable.

004.01(C)(v)(3) RECORD RETENTION. Forms DM-5, MC-9NF, or the Nursing Facility Level of Care Determination Form must be maintained in the client's medical record in the facility where the client resides.

004.01(C)(vi) EMERGENCY ADMISSIONS. In the case of an emergency admission, the intermediate care facility for individuals with developmental disabilities (ICF/DD) facility will follow the admission process according to this chapter. The facility must

hold the pre-admission meeting on the day the client enters the facility and will document the reason for the admission. However, the facility is given seven calendar days to complete the needed assessments to verify the client's need for intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care, health and nutritional needs, skills and skill deficits and training needs.

004.01(C)(vii) ADMISSION NOTIFICATION. The intermediate care facility for individuals with developmental disabilities (ICF/DD) must notify Medicaid within 10 days of admitting a client into the intermediate care facility for individuals with developmental disabilities (ICF/DD).

004.01(D) LEVEL OF CARE.

004.01(D)(i) INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) LEVEL OF CARE CRITERIA. Medicaid applies the following criteria to determine the appropriateness of intermediate care facility for individuals with developmental disabilities (ICF/DD) services on admission and at each subsequent review:

(1) The individual has a diagnosis of an intellectual disability or a related condition, which has been confirmed by prior diagnostic evaluations and standardized tests and sources independent of the intermediate care facility for individuals with developmental disabilities (ICF/DD); and
(2) The individual can benefit from active treatment as defined in 42 CFR 483.440(a) and 471 NAC 31-002. In addition, the following criteria apply:
    (a) The individual has a related condition and the independent qualified intellectual disabilities professional (QIDP) assessment identifies the related condition has resulted in substantial functional limitations in three or more of the following areas of major life skills: self-care, receptive and expressive language, learning, mobility, self-direction, or capacity for independent living. These substantial functional limitations indicate that the individual needs a combination of individually planned and coordinated special interdisciplinary care, a continuous active treatment program, treatment, and other services which are lifelong or of extended duration;
    (b) A Medicaid-eligible individual has a dual diagnosis of developmental disability or a related condition and a mental illness. The developmental disability or related condition has been verified as the primary diagnosis by both an independent qualified intellectual disabilities professional (QIDP) and a mental health professional in which their scope of practice allows them to diagnose mental illness:
        (i) Historically there is evidence of missed developmental stages, due to developmental disability or a related condition;
        (ii) There is remission in the mental illness and it does not interfere with intellectual functioning and participation in training programs; and
        (iii) The diagnosis of developmental disability or a related condition takes precedence over the diagnosis of mental illness; and
    (c) When the individual does not have substantial functional limitations in self-care skills, the individual must have substantial functional limitations in at

least the life skill area for capacity for independent living along with two other life skill areas.

004.01(D)(ii) APPROVAL OF THE INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) LEVEL OF CARE. The intermediate care facility for individuals with developmental disabilities (ICF/DD), after determining to admit the client, must submit the following to the Medicaid review team to request approval for Medicaid payment of intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care for the client:

(a) Completed Form MC-9NF, or Nursing Facility Level of Care Determination Form;
(b) The physician's examination or completed Form DM-5. The physician who conducted the examination must sign and date Form DM-5 with the physician's determination of level of care indicated. If the physician's examination is submitted instead of Form DM-5, it must include a clear indication that the physician conducting the examination certifies the client requires intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care;
(c) A current dental examination, completed within 12 months before admission or within one month after the date of admission;
(d) Completed Form DM-5-DD-LTC as instructed in Appendix 471-000-5;
(e) The independent qualified intellectual disabilities professional (QIDP) assessment;
(f) The individual program plan (IPP) and individualized educational plan (IEP), if school-aged, from the previous provider;
(g) Mental health evaluation performed by a mental health professional;
(h) The pre-admission evaluation; and
(i) For out-of-state intermediate care facility for individuals with developmental disabilities (ICF/DD) verification that the client's needs cannot be met by a Nebraska provider. Exceptions may be made by the department in its own discretion for this requirement.

004.01(D)(ii)(1) ONSITE OBSERVATIONS. When Medicaid receives all required documentation, Medicaid reviews all submitted documentation and determines whether the intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care is appropriate. In the event Medicaid determines the documentation available for review does not provide adequate information to make a determination of whether the intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care is appropriate, Medicaid may conduct onsite observations of the client at the facility, interview facility staff, or request additional information from the intermediate care facility for individuals with developmental disabilities (ICF/DD) facility. If additional information is needed, the intermediate care facility for individuals with developmental disabilities (ICF/DD) must provide the necessary information upon the request of Medicaid. Medicaid will notify the intermediate care facility for individuals with developmental disabilities (ICF/DD) of any decision, and will notify the client as well as the parent or guardian of an adverse decision.

004.01(D)(iii) INAPPROPRIATE LEVEL OF CARE. On admission, and at each subsequent review, the facility must ensure which services provided in the intermediate care facility for individuals with developmental disabilities (ICF/DD) are the least restrictive alternative. The following do not meet criteria for intermediate care facility for individuals with developmental disabilities (ICF/DD) services:

(a) Mental illness is the primary barrier to independent living within a normalized environment; or
(b) The intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care is not the least restrictive alternative, including when the client:
    (i) Exhibits skills and needs comparable to those of persons with similar needs living independently or semi-independently in the community;
    (ii) Exhibits skills and needs comparable to those of persons at nursing facility (NF) level of care; or
    (iii) Is able to function with little supervision or in the absence of a continuous active treatment program.

004.01(D)(iii)(1) INITIAL REVIEW. For those clients who, at the time of initial review, are found to be inappropriate for intermediate care facility for individuals with developmental disabilities (ICF/DD) care, Medicaid limits Medicaid coverage to a maximum of 30 days, beginning with the day Medicaid determines that the level of care is inappropriate.

004.01(D)(iii)(2) CLIENT RESIDING AT THE FACILITY. For those clients who, while residing at an intermediate care facility for individuals with developmental disabilities (ICF/DD), are found to be inappropriate for intermediate care facility for individuals with developmental disabilities (ICF/DD) care in accordance with the provisions of this chapter below, Medicaid limits Medicaid coverage to a maximum of 60 days, beginning with the day the recommendation becomes final.

004.01(D)(iii)(2)(a) DEPARTMENT RECOMMENDATION. After Medicaid reviews the client's health, habilitative, and social needs and determines the client no longer meets criteria for intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care according to this chapter, the following process will take place:

(i) Medicaid will send a notification letter to the client's attending physician and the intermediate care facility for individuals with developmental disabilities (ICF/DD)'s qualified intellectual disabilities professional (QIDP) giving them an opportunity to respond. Based on the responses, Medicaid may take the following actions:
    (1) If appropriate justification for continued intermediate care facility for individuals with developmental disabilities (ICF/DD) care is provided within the time frames specified in the letter of notification, the recommendation may be withdrawn; or
    (2) In the absence of appropriate or timely justification, the recommendation becomes final;
(ii) Once the responses of the attending physician and intermediate care facility for individuals with developmental disabilities (ICF/DD) qualified

intellectual disabilities professional (QIDP) have been reviewed, Medicaid will send written notification of the decision to the intermediate care facility for individuals with developmental disabilities (ICF/DD), the attending physician, and the intermediate care facility for individuals with developmental disabilities (ICF/DD)'s qualified intellectual disabilities professional (QIDP); and

(iii) If the recommendation is upheld, the intermediate care facility for individuals with developmental disabilities (ICF/DD) must document a specific and appropriate discharge plan in compliance with 42 CFR 483.440(b) to assist the client in preparing for alternate arrangements.

<u>004.01(D)(iii)(2)(b)</u> <u>INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) RECOMMENDATION.</u> Intermediate care facility for individuals with developmental disabilities (ICF/DD) staff must submit requests for a change of level of care between reviews to Medicaid in writing along with supporting documentation. If the client needs to be discharged to an alternative setting:

(i) The intermediate care facility for individuals with developmental disabilities (ICF/DD) must notify the individual, family or legal guardian, and the Department of Health and Human Services' Developmental Disabilities Division, Service Coordination (DDD SC) of the recommendation;
(ii) The intermediate care facility for individuals with developmental disabilities (ICF/DD) must assist the client, family, or legal guardian in seeking appropriate alternatives;
(iii) The intermediate care facility for individuals with developmental disabilities (ICF/DD) must document which other alternatives were explored and the responses;
(iv) The present intermediate care facility for individuals with developmental disabilities (ICF/DD) must provide services to meet the needs of the client and must refer to appropriate agencies for services until the expiration of the 60 day coverage period or until an appropriate alternative is available, whichever comes first;
(v) The intermediate care facility for individuals with developmental disabilities (ICF/DD), and others involved, must make available to the Medicaid review team the documentation of active exploration for appropriate alternatives; and
(vi) Upon receipt of all the necessary information, the intermediate care facility for individuals with developmental disabilities (ICF/DD) must document a specific and appropriate discharge plan in compliance with 42 CFR 483.440(b) to assist the client in preparing for alternate arrangements.

<u>004.01(D)(iii)(2)(c)</u> <u>ADDITIONAL RECOMMENDATIONS.</u> In the event that any State or Federal survey or certification agency determines a client no longer needs or benefits from intermediate care facility for individuals with developmental disabilities (ICF/DD) services, Medicaid will follow the process outlined in 471 NAC 31-004.01(D)(iii)(2)(a).

004.01(D)(iv) INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) LEVEL OF CARE CONTINUANCE. A client who currently resides in an intermediate care facility for individuals with developmental disabilities (ICF/DD) who has been determined inappropriate for that level of care may be approved by the Medicaid review team to continue at the intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care, for a limited period of time. The continuance may be approved when the intermediate care facility for individuals with developmental disabilities (ICF/DD) presents written documentation of its ongoing efforts to obtain an appropriate alternative living situation for the client.

004.01(E) OUT-OF-STATE SERVICES. Medicaid covers out-of-state intermediate care facility for individuals with developmental disabilities (ICF/DD) services in accordance with 471 NAC 1. Evidence must be provided that the client's needs cannot be met by providers in Nebraska. Out-of-State services may also be permitted by department discretion in cases where the client's current living situation is bordering an out-of-state community where an appropriate provider is located.

004.01(F) INDEPENDENT QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL (QIDP) ASSESSMENT. The intermediate care facility for individuals with developmental disabilities (ICF/DD) facility must ensure an independent qualified intellectual disabilities professional (QIDP) assessment is completed for all clients during the admission process. The facility is responsible for securing the qualified intellectual disabilities professional (QIDP), including payment for such services. An individual program plan (IPP) is acceptable in lieu of the independent qualified intellectual disabilities professional (QIDP) assessment as long as the individual program plan (IPP) provides accurate and current information regarding the client's strengths and needs. The Individual Program Plan (IPP) cannot have an implementation date of more than 12 months prior to the client's admission to the facility. The facility must ensure:

(1) The qualified intellectual disabilities professional (QIDP) is not associated with the facility in any manner;
(2) The qualified intellectual disabilities professional (QIDP) meets requirements at 42 CFR 480.430 to be considered a qualified intellectual disabilities professional (QIDP);
(3) The qualified intellectual disabilities professional (QIDP) assessment is completed no later than the date of and, no more than three months prior to, the client's admission to the facility; and
(4) The independent qualified intellectual disabilities professional (QIDP) completes the assessment in accordance with requirements at 471 NAC 31-004.01(F)(i).

004.01(F)(i) QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL (QIDP) ASSESSMENT PROCESS. To ensure completion of an accurate, comprehensive assessment, the qualified intellectual disabilities professional (QIDP) must:

(1) Interview and conduct observations of the client in their living environment, and vocational environment, if possible;
(2) Conduct a functional and complete assessment of skills, using an appropriate standardized assessment tool, in order to identify the client's present skills and skill-deficit areas;

(3) Review records to verify the diagnosis of an intellectual disability or related condition, including the most recent psychological assessment, as well as medical records;
(4) Review of available, relevant client records, including medical and programming records, to aid in determining the client's skills, skill-deficits, training needs, and possible assessment needs;
(5) Submit a written report to the facility which summarizes the results of the qualified intellectual disabilities professional (QIDP) assessment. The written report must include the following:
   (a) The client's name, age, and date of birth;
   (b) The client's current address or place of residence;
   (c) The client's guardianship status;
   (d) The client's current diagnosis and physical disabilities;
   (e) Sources of information gathered to complete the assessment;
   (f) Any independent assessments or evaluations conducted as part of the assessment process;
   (g) Date(s) the assessment was conducted, as well as the date of the written report;
   (h) A narrative summarizing the client's skills and skill-deficits, including use of adaptive equipment, with regard to:
      (i) Self-care;
      (ii) Communication, receptive and expressive;
      (iii) Learning abilities;
      (iv) Mobility;
      (v) Self-direction, adaptive skills, including but not limited to behavior, social skills and decision-making skills;
      (vi) Independent living skills, including but not limited to money-handling, daily household tasks, and community access;
      (vii) Vocational skills; and
      (viii) Recommendations for each skill area for training, treatment needs, further assessment and evaluation needs, needed adaptive equipment, and possible needs for additional services. The recommendations must be determined without regard to the availability of services;
   (j) Summary of progress, or lack of progress, in previous service settings;
   (k) The qualified intellectual disabilities professional (QIDP)'s determination of the type of service setting needed to meet the client's treatment needs. This determination must not identify a specific facility or provider; and
   (l) The qualified intellectual disabilities professional (QIDP)'s name, signature, and address.

004.01(G) INDIVIDUAL PROGRAM PLAN (IPP). Within 30 days of a client's admission to the intermediate care facility for individuals with developmental disabilities (ICF/DD), the interdisciplinary team (IDT) must prepare an individual program plan (IPP). The individual program plan (IPP) must specify long-term goals, short-term objectives, and services to address prioritized needs in a continuum of development; outlining projected progressive, sequential, steps and the developmental consequences, outcomes, of training programs and services. Additionally, the individual program plan (IPP) must

address therapeutic leave. Long-term goals and short-term objectives for all formal training to be provided are based on identified needs. Objectives must be person-centered, stated in specific, observable, and measurable terms so the level of skill acquisition can be assessed. The long-term goal must be the culmination of its short-term objectives. Each client's individual program plan (IPP), functional assessments, and nursing plan of care must be made available to all relevant staff and the interdisciplinary team (IDT). As soon as the interdisciplinary team (IDT) has formulated a client's individual program plan (IPP), each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan (IPP).

004.01(G)(i) REVIEW AND REVISION OF THE INDIVIDUAL PROGRAM PLAN (IPP). The interdisciplinary team (IDT) must review each individual program plan (IPP) at least quarterly, and revise each individual program plan (IPP) as needed. At least annually, the Interdisciplinary Team (IDT) reviews and updates each client's individual program plan (IPP), including ongoing exploration of alternatives. Each interdisciplinary team (IDT) member's assessment must be completed before this annual review. The revisions of the individual program plan (IPP) are based on current needs as identified by the comprehensive functional assessments and the client's response to training, as required by 42 CFR 456.380(c) and 483.440. The qualified intellectual disabilities professional (QIDP) and other interdisciplinary team (IDT) members must each routinely review aspects of the client's active treatment process to determine if the client's needs are effectively addressed and if revisions are needed.

004.01(H) BED HOLDING. Medicaid covers a reserved bed in an intermediate care facility for individuals with developmental disabilities (ICF/DD) during a client's absence, due to hospitalization for an acute condition, and for therapeutically indicated home visits. Coverage of 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;
(3) Therapeutic leave bed holding is limited to reimbursement for 36 days per calendar year, even if the client has a stay in more than one intermediate care facility for individuals with developmental disabilities (ICF/DD) during the calendar year. Bed holding days are prorated when a client is admitted after January 1; and
(4) Facility staff must work with the client as well as parent or guardian to plan the use of the allowed 36 days of therapeutic leave for the calendar year.

004.01(H)(i) SPECIAL LIMIT. When the limitation for therapeutic leave interferes with an approved therapeutic or habilitative program, the intermediate care facility for individuals with developmental disabilities (ICF/DD) 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; and
(4) The individual program plan (IPP).

004.02 COVERED SERVICES.

004.02(A) ANNUAL PHYSICAL EXAMINATION. Medicaid requires that all individuals eligible for Medicaid residing in long-term care facilities have an annual physical examination. The physician or other medical professional, operating within their scope of practice according to State law and based on their authority to prescribe continued treatment, determines the extent of the examination for individuals eligible for Medicaid based on medical necessity. For the annual physical exam, a CBC and urinalysis will not be considered "routine" and is reimbursed based on the medical practitioner's orders. The results of the examination must be recorded in the individual's medical record.

004.02(B) HEALTH CARE SERVICES. The intermediate care facility for individuals with developmental disabilities (ICF/DD) must ensure that intermediate care facility for individuals with developmental disabilities (ICF/DD) clients receive appropriate health care services. If appropriate health care services cannot be provided by facility staff, the care must be contracted from providers who are licensed or certified as applicable.

004.02(B)(i) PHYSICIAN SERVICES.

004.02(B)(i)(1) PHYSICIAN'S OVERALL PLAN OF CARE. Before admission to an intermediate care facility for individuals with developmental disabilities (ICF/DD), or before authorization for payment, a physician must establish a written plan of care for each client. The client's interdisciplinary team must review the client's plan of care at least every 90 days. The plan of care must include:
(a) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
(b) A description of the functional level of the client;
(c) Objectives;
(d) Any orders for:
(i) Medications;
(ii) Treatments;
(iii) Restorative and rehabilitative services;
(iv) Activities;
(v) Therapies;
(vi) Social services;
(vii) Diet; and
(viii) Special procedures designed to meet the objectives of the plan of care;
(e) Plans for continuing care, including review of and modification of the plan of care;
(f) A determination of whether the client needs a medical care plan; and
(g) Plans for discharge.

004.02(B)(i)(2) STANDARDS FOR PHYSICIAN SERVICES. The facility must ensure the availability of physician services 24 hours a day. The physician must develop, in coordination with licensed nursing personnel, a medical care plan for a client if the physician determines the individual requires 24-hour licensed nursing care. This plan must be integrated in the individual program plan. To the extent

permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section. The facility must provide or obtain preventive and general medical care, as well as annual physical examinations, of each client that at a minimum include the following:

(a) Evaluation of vision and hearing;
(b) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics;
(c) Routine screening laboratory examinations, as determined necessary by the physician, and special studies when needed; and
(d) Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the Nebraska Department of Health and Human Services Regulation and Licensure.

004.02(B)(i)(3) PHYSICIAN PARTICIPATION IN THE INDIVIDUAL PROGRAM PLAN. A physician must participate in:

(a) The establishment of each newly admitted client's initial individual program plan as required by 42 CFR 456.380; and
(b) If appropriate, the review and update of an individual program plan as part of the interdisciplinary team (IDT) process either in person or through written report to the interdisciplinary team (IDT).

004.02(B)(i)(4) RECERTIFICATION. The physician, the physician's assistant or nurse practitioner, must recertify in writing the client's continued need for the intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care at least once every 365 days, and at any time the client requires a different level of care. The extended recertification period in no way indicates that one year is the appropriate length of stay for a client in an intermediate care facility for individuals with developmental disabilities (ICF/DD). The interdisciplinary team responsible for the client's care determines the client's length of stay.

004.02(B)(i)(4)(a) DELEGATION. The physician's assistant, or nurse practitioner, may recertify the client's need under the general supervision of a physician when the physician formally delegates this function to the physician's assistant or nurse practitioner.

004.02(B)(i)(4)(b) SIGNATURE. The physician, the physician's assistant, or nurse practitioner must sign, or signature stamp and initial, and date the recertification clearly identifying the medical professional as a physician, physician's assistant, or nurse practitioner. Electronic signatures will also be accepted.

004.02(B)(i)(4)(c) RECORDS. Facility staff must maintain the recertification in the client's medical record in the facility where the client resides.

004.02(B)(i)(4)(d) RECORD RETENTION. The physician must record recertifications accomplished by on-site visits to the facility in the client's

medical record. The physician is paid according to 471 NAC 18 for a nursing home visit. The physician must use the appropriate procedure codes when billing Medicaid for this service.

004.02(B)(ii) NURSING SERVICES.

004.02(B)(ii)(1) STANDARDS FOR NURSING SERVICES. The facility must provide clients with nursing services in accordance with their needs. These services must include:

(a) Participation in the pre-admission evaluation and in the development, review, and update of an individual program plan as part of the interdisciplinary team (IDT) process;
(b) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that a client requires such a plan;
(c) For those clients certified as not needing a medical care plan, a review of their health status which must:
    (i) Be by direct physical examination;
    (ii) Be by a licensed nurse;
    (iii) Be on a quarterly or more frequent basis depending on need;
    (iv) Be recorded in the record; and
    (v) Result in any necessary action (including referral to a physician to address health problems;
(d) Other nursing care as prescribed by the physician or as identified by needs;
(e) Implementing, with other members of the interdisciplinary team (IDT), appropriate protective and preventive health measures which include, but are not limited to:
    (i) Training clients and staff as needed in appropriate health and hygiene methods;
    (ii) Control of communicable diseases and infections, including the instructions of other personnel in methods of infection control; and
    (iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients; and
(f) The nursing plan of care as part of the individual program plan (IPP) must be revised as necessary, but reviewed at least quarterly.

004.02(B)(ii)(2) STANDARDS FOR NURSING STAFF. Nurses providing services in the facility must have a current license to practice in the state. The facility must employ, or arrange for, licensed nursing services sufficient to care for client's health needs, including those clients with medical care plans.

004.02(B)(ii)(2)(a) ADDITIONAL REQUIREMENTS. The facility must utilize registered nurses as appropriate and required by state law, to perform the health services specified in this section. If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal written arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse. Non-licensed nursing

personnel who work with clients under a medical care plan must do so under the supervision of licensed nursing personnel.

004.02(B)(iii) DENTAL CARE. All intermediate care facility for individuals with developmental disabilities (ICF/DD) clients must have a dental evaluation:
(a) Within 12 months before admission or within one month after admission; and
(b) At least annually thereafter.

004.02(B)(iii)(1) STANDARDS FOR DENTAL SERVICES. The facility must provide, or make arrangements for, comprehensive diagnostic and treatment services for each client from qualified personnel. This includes licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. If appropriate, dental professionals must participate, in the development, review, and update of an individual program plan as part of the interdisciplinary team (IDT) process either in person or through written report to the interdisciplinary team (IDT). The facility must provide education and training in the maintenance of oral health.

004.02(B)(iii)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICES. Comprehensive dental diagnostic services include:
(a) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility, unless the examination was completed within 12 months before admission;
(b) Periodic examination and diagnosis performed at least annually, including radiographs, when indicated and detection of manifestations of systemic disease; and
(c) A review of the results of examination and entry of the results in the client's dental record.

004.02(B)(iii)(3) COMPREHENSIVE DENTAL TREATMENT. The facility must ensure comprehensive dental treatment services which include:
(a) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and
(b) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

004.02(B)(iii)(4) DOCUMENTATION OF DENTAL SERVICES. If the facility maintains an in-house dental service, the facility must keep a permanent dental record for each client, with a dental summary maintained in the client's living unit. If the facility does not maintain an in-house dental service, the facility must obtain a dental summary of the results of dental visits and maintain the summary in the client's medical record.

004.02(C) ITEMS COVERED PER DIEM PAYMENTS. The following items are included in the per diem payment made by Medicaid to the intermediate care facility for individuals with developmental disabilities (ICF/DD).

004.02(C)(i) ROUTINE SERVICES. Routine intermediate care facility for individuals with developmental disabilities (ICF/DD) services include regular room, dietary, and nursing services; social services and active treatment program as required by any applicable federal and state certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items which routine services may include are:

(1) All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as blood and urine; hand-feeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care, excluding professional barber and beauty services, nail care, shaving, and oral hygiene; enema;
(2) Active treatment: The facility must provide a continuous active treatment program, as determined necessary by each client's interdisciplinary team, including physical therapy, occupational therapy, speech therapy, recreational therapy, and pre-vocational services and related supplies to include, but not limited to, augmentative communication devices with related equipment and software, as described in each client's Individual Plan of Care;
(3) Items which are furnished routinely and relatively uniformly to all residents. These items include gowns, linens, water pitchers, basins, and bedpans;
(4) Items stocked at nursing stations on each floor or in each home in gross supply and distributed or used individually, including alcohol, applicators, cotton balls, Band Aids, incontinency care products, oxygen and oxygen equipment, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports, hydrogen peroxide, over the counter enemas, tests, tongue depressors, hearing aid batteries, facial tissue, personal hygiene items;
(5) Items which are used by individual residents, but are reusable and expected to be available, such as; ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, and all other durable medical equipment not listed in 471 NAC 31-004.03(A)(ii);
(6) Nutritional supplements and supplies used for oral, enteral, or parenteral, feeding;
(7) Laundry services, including personal clothing;
(8) Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service; and
(9) Repair of medically necessary facility owned and purchased durable medical equipment and their maintenance.

004.02(C)(ii) INJECTIONS. The resident'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.

004.02(C)(iii) TRANSPORTATION. The facility is responsible for ensuring that all clients receive appropriate medical care. The facility must provide transportation to

client services which are reimbursed by Medicaid including, but not limited to, medical and dental services. 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.

004.03 NON-COVERED SERVICES.

004.03(A) ITEMS NOT INCLUDED IN PER DIEM RATES. Medicaid may cover services provided in an intermediate care facility for individuals with developmental disabilities (ICF/DD) which are not included in the per diem payment outlined in 471 NAC 31-004.02(C). Coverage of additional items and services is provided in accordance with each specific NAC Title 471 Chapter.

004.03(A)(i) PAYMENTS TO INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) PROVIDER SEPARATE FROM THE PER DIEM RATE. Items for which payment may be made to intermediate care facility for individuals with developmental disabilities (ICF/DD) 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 471 NAC 7.

(1) Non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles;
(2) Air fluidized bed units and low air loss bed units; and
(3) Negative pressure wound therapy.

004.03(A)(ii) PAYMENTS TO OTHER PROVIDERS. Items for which payment may be authorized to non-intermediate care facility for individuals with developmental disabilities (ICF/DD) providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

(1) Legend drugs, over the counter drugs and compounded prescriptions, including intravenous solutions and dilutants;
(2) Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids;
(3) Orthoses as defined in 471 NAC 7;
(4) Prostheses as defined in 471 NAC 7; and
(5) Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meets the definitions in 471 NAC 4.

004.03(A)(ii)(5)(a) AMBULANCE SERVICES MEDICAL NECESSITY. 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 does not make payment for ambulance service.

004.03(A)(ii)(5)(b) NON-EMERGENCY AMBULANCE SERVICES. Non-emergency ambulance transports to a physician or practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport and when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the intermediate care facility for individuals with developmental disabilities (ICF/DD)).

005. BILLING AND PAYMENT FOR INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) SERVICES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS.

005.01(B)(i) REPORTING BED HOLDING DAYS. Intermediate care facility for individuals with developmental disabilities (ICF/DD) must report bed holding days on the appropriate claim. The appropriate bed holding days are reported as outlined in claim submission instructions; the “nursing facility days” are adjusted to the actual number of days the client was present in the intermediate care facility for individuals with developmental disabilities (ICF/DD) at midnight.

005.01(B)(ii) BILLING FOR THE ANNUAL PHYSICAL EXAMINATION. If the annual physical examination is performed solely to meet the Medicaid requirement, the physician must use the appropriate Healthcare Common Procedure Coding System code and submit the claim to Medicaid. If the physical examination is performed for diagnosis or treatment of a specific symptom, illness, or injury and the individual has Medicare or other third party coverage, the physician must submit the claim through the usual Medicare or other third party process.

005.02 PAYMENT.

005.02(A) 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 individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS. Medicaid will pay for intermediate care facility for individuals with developmental disabilities (ICF/DD) services only when prior authorized.

005.02(B)(i) INITIAL CERTIFICATION. Medicaid must approve payment to an intermediate care facility for individuals with developmental disabilities (ICF/DD) for services rendered to an eligible client beginning on the date:

(1) The client is formally admitted to the intermediate care facility for individuals with developmental disabilities (ICF/DD) following the admission evaluation process;
(2) The client's eligibility for Medicaid is effective, if later than the admission date; or
(3) The date Form DM-5 is signed and dated, if Form DM-5 is signed and dated more than 48 hours (two working days) after admission or the date eligibility is determined. If the physician's examination is submitted instead of Form DM-5, the date the physician's examination is signed and dated, if this execution is more than 48 hours (two working days) after admission or the date eligibility is determined. If Form DM-5 is signed and dated more than 30 days before admission, or the date eligibility is determined, Medicaid will not approve payment unless a new or updated Form DM-5 is obtained.

005.02(B)(ii) DEATH ON DAY OF ADMISSION. If a client is admitted to an intermediate care facility for individuals with developmental disabilities (ICF/DD) and dies before midnight on the same day, Medicaid allows payment for one day of care.

005.03 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) RATE REQUIREMENTS.

005.03(A) REPORTING REQUIREMENTS AND RECORD RETENTION. Providers must submit cost and statistical data on Form FA-66, Long-Term Care Cost Report, and Form FA-66 Intermediate Care Facility For Individuals With Developmental Disabilities (ICF/DD), Long-Term Care Cost Report Supplement. 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 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 Medicaid for verification of the reported data. I f records are not accurate, sufficiently detailed, or readily available, Medicaid may correct, reduce, or eliminate data. Providers are notified of changes.

005.03(A)(i) TIMELINE. Each facility must complete the required schedules and submit the original, signed Report to Medicaid 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.

005.03(A)(ii) FAILURE TO PROVIDE. When a provider fails to file a cost report prior to expiration of 90 days from the close of the reporting period, Medicaid will suspend payment. At the time the suspension is imposed, Medicaid 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 are deemed overpayments. The provider must continue to care for residents and maintain levels of care if Medicaid suspends payment.

005.03(A)(iii) LEGAL ACTION. If the provider takes no action to comply with the obligation, Medicaid may refer the case for legal action.

005.03(A)(iv) SUMS DUE. If a cost report has not been filed, the sum of the following is due:

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

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

005.03(A)(vi) RETENTION OF RECORDS. 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. Medicaid retains all cost reports for at least five years after receipt from the provider.

005.03(A)(vii) OTHER SERVICES. Facilities providing any services other than certified intermediate care facility for individuals with developmental disabilities (ICF/DD) services must report all 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 Medicaid before the report period. Any Medicare certified facility must not report costs for a level of care to Medicaid which have been reported for a different level of care on a Medicare cost report.

005.03(B) AUDITS. Medicaid will perform an initial desk audit on all cost reports. Payment rates are determined after the initial desk audit is completed. Subsequent desk audits or a periodic field audit may also be performed for each cost report. Performance of a desk audit includes the review of information submitted, and may require additional information to be submitted by the provider. Performance of a field audit requires an onsite visit to the provider to review information.

005.03(B)(i) SUBSEQUENT AUDITS. Selection of subsequent desk audits and field audits are made as determined necessary by Medicaid to maintain the integrity of the

program. Medicaid 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 are retained by Medicaid for at least three years following the completion and finalization of the audit.

005.03(B)(ii) INITIAL AUDITS. An initial desk audit is completed on all cost reports. Payment rates are determined after the initial desk audit is completed.

005.03(B)(iii) SUBSEQUENT AUDITS. All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. To initiate a subsequent desk audit, Medicaid sends a notification letter to the provider identifying the primary period(s) and subject(s) to be desk audited. The provider must deliver copies of schedules, summaries, or other records requested by Medicaid as part of any desk audit.

005.03(B)(iv) FIELD AUDITS. All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by Medicaid. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period that has not previously been subjected to a field audit. The scope of each field audit is determined by Medicaid. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and Medicaid, any records requested by Medicaid as part of a field audit.

005.03(C) SETTLEMENT AND RATE ADJUSTMENTS. When an audit has been completed on a cost report, Medicaid will determine if an adjustment to the rate is required. If necessary, a settlement amount is determined. Payment, or arrangements for payment, of the settlement amount, by either Medicaid 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 Medicaid for audit adjustments not included in the appeal request. If an audit is completed during the applicable rate period, Medicaid will adjust the rate for payments made after the audit completion.

005.03(C)(i) FINAL ADJUSTMENT. Medicaid 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, Medicaid will immediately begin recovery from future facility payments until the amount due is recovered.

005.03(C)(ii) REPORT. Medicaid 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.

005.03(D) APPEAL PROCESS. Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request

an appeal in writing from the Director of Medicaid within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis or explanation of each item. After the Director issues a determination in regard to the administrative appeal, Medicaid 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.

005.03(E) ADMINISTRATIVE FINALITY. Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by Medicaid within three years of the date of notice of the decision or inaction. "Reopening" means an action taken by the Director of Medicaid to reexamine or question the correctness of a determination or decision that is otherwise final. The Director is the sole authority in deciding whether to reopen. A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted. The action may be taken:
(i) On the initiative of Medicaid within the three-year period;
(ii) In response to a written request from a provider or other entity within the three-year period. Whether the 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
(iii) Any time fraud or abuse is suspected.

005.03(F) SANCTIONS. See 471 NAC 2.

005.03(G) CHANGE OF HOLDER OF PROVIDER AGREEMENT. A holder of a provider agreement receiving payments under this section must notify Medicaid 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due Medicaid 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 is required to provide a guarantee of repayment of Medicaid's estimated settlement either by payment of that amount to Medicaid, providing evidence that another provider receiving payments under this section 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.

005.03(G)(i) UNPAID SETTLEMENT. Medicaid will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to Medicaid 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 Medicaid by making a written request.

005.03(H) ADDITIONAL PAYMENT TO NON-STATE-OPERATED INTERMEDIATE CARE FACILITY FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) PROVIDERS. In accordance with Neb. Rev. Stat. § 68-1804(3)(d), non-state-operated intermediate care facility for individuals with developmental disabilities (ICF/DD) providers may be eligible to participate in an additional distribution. For fiscal years 2011-12, 2012-

13, and 2013-14, Medicaid determines the amount available in the intermediate care facility for individuals with developmental disabilities (ICF/DD) Reimbursement Protection Fund. Following the distributions of the payments identified in Neb. Rev. Stat. § 68-1804(3)(a-c), the amount remaining in the Fund, not to exceed a total of $600,000, is distributed to non-State-operated intermediate care facility for individuals with developmental disabilities (ICF/DD) providers.

006. UTILIZATION REVIEW. Utilization reviews (UR) of Nebraska Medicaid clients residing in an intermediate care facility for individuals with developmental disabilities (ICF/DD) are conducted by the Medicaid review team to determine if clients continue to meet intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care. The utilization review (UR) also evaluates the effectiveness of services provided to clients by intermediate care facilities for individuals with developmental disabilities (ICF/DD). Utilization reviews (UR) will occur at least every six months. The intermediate care facility for individuals with developmental disabilities (ICF/DD) must retain documentation of the utilization review (UR) in the client's permanent record.

006.01 MEDICAID REVIEW TEAM.

006.01(A) MEDICAID REVIEW TEAM RESPONSIBILITIES. The Medicaid review team will:

(1) With input from facility staff as needed, establish a utilization review (UR) schedule for each intermediate care facility for individuals with developmental disabilities (ICF/DD);
(2) Notify the facility of the utilization review (UR) at least 30 days prior to the review;
(3) Provide the facility a listing of the clients that are reviewed;
(4) Provide direction to the facility regarding forms and records required for the review;
(5) Determine whether each client is approved for a continued stay for a maximum of six months or does not meet criteria for a continued stay. When a continued stay is not approved, follow the appropriate procedures; and
(6) Notify the facility of the results of the utilization review (UR).

006.01(A)(i) EXPANSION OF REVIEW PROCESS. The Medicaid review team has the authority to expand the review process as needed and may include the review of additional client records, and interviews with clients and facility staff. In the event the Medicaid review team determines the documentation available for review does not provide adequate information to make a determination of whether the intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care is appropriate, the Medicaid review team may conduct onsite observations and interview with the client at the facility, interview facility staff, and request additional information from the intermediate care facility for individuals with developmental disabilities (ICF/DD).

006.01(B) INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). Within 10 days following receipt of the utilization review results the intermediate care facility for individuals with developmental disabilities (ICF/DD) must respond to the department in writing, and must include the following information:

(1) A complete plan of correction that addresses all identified findings and recommendations;
(2) Changes in level of care;
(3) Each individual recommendations and the examples of problems; and
(4) Projected dates of completion on each of the above.

006.01(B)(i) FAILURE TO RESPOND. If the facility fails to submit a timely and/or appropriate response, the Department may take administrative sanctions or any of the following actions.
(a) The Department may suspend Title XIX reimbursement for a client or the entire reimbursement for the facility; or
(b) Clients may be transferred to another facility.

006.01(C) COMPOSITION OF THE MEDICAID REVIEW TEAM. The Medicaid review team must include a Medicaid reviewer who is knowledgeable in working with individuals with developmental disabilities and related conditions. The team may also include any of the following:
(1) A physician;
(2) A registered nurse; and
(3) Other professional personnel as needed based on the review process.

006.01(C)(i) PHYSICIAN. The Department is the final authority for findings, patient care recommendations, and official action.

006.01(C)(ii) REGISTERED NURSE. The registered nurse may consult and participate in the utilization review (UR) process, should there be potential issues related to nursing or medical services.

006.01(C)(iii) OTHER PROFESSIONAL PERSONNEL. Other professional personnel may consult and participate in the utilization review (UR) process, based on their expertise related to services in which the Medicaid review team identified possible issues.

007. HOSPICE SERVICES.

007.01 DEFINITION OF HOSPICE. Hospice or hospice services must meet the definition outlined in 471 NAC 36.

007.02 STANDARDS FOR PARTICIPATION. To participate in Medicaid, a hospice must be a public agency or private organization, or a subdivision of either, primarily engaged in providing care to terminally ill individuals and is certified for participation in Medicare as a hospice.

007.02(A) PROVIDER ENROLLMENT. To complete the provider enrollment process for adult clients, the hospice must meet the following conditions:
(i) The hospice must have a signed, written, non-resident-specific contract with the intermediate care facility for individuals with developmental disabilities (ICF/DD); and

(ii) The hospice must complete and submit a Nebraska Medicaid provider agreement in its entirety to Medicaid for each contracted intermediate care facility for individuals with developmental disabilities (ICF/DD).

007.03 PRIOR AUTHORIZATION PROCESS. The following must be completed before Medicaid authorizes payment to the hospice for board and room:

(A) The hospice must request prior authorization for payment by paper or electronically. If requesting prior authorization by paper, the hospice must provide Medicaid all records listed below:
- (i) Form MC-9NF, or Nursing Facility Level of Care Determination Form;
- (ii) Physician's order for hospice services, including rationale for the need of hospice services including certification of terminal illness;
- (iii) Hospice plan of care, including the responsibilities of the intermediate care facility for individuals with developmental disabilities (ICF/DD) as part of the hospice services;
- (iv) List of hospice covered medications and pharmacy notification;
- (v) List of hospice covered medical appliances, supplies, and therapies; and
- (vi) The hospice must obtain prior authorization for the actual hospice service when Medicaid is the primary payer.

007.04 BILLING AND PAYMENT FOR HOSPICE BOARD AND ROOM.

007.04(A) BILLING. Hospice providers must bill Medicaid on the appropriate claim form or electronic format.

007.04(B) PAYMENT OF BOARD AND ROOM TO THE HOSPICE PROVIDER. Medicaid pays the hospice for the client's board and room in the intermediate care facility for individuals with developmental disabilities (ICF/DD) 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 intermediate care facility for individuals with developmental disabilities (ICF/DD) facility;
5. The client's medical needs must meet the Medicaid criteria and be approved for intermediate care facility for individuals with developmental disabilities (ICF/DD) level of care;
6. Prior authorization requirements must be met; and
7. The client is an adult.

007.04(B)(i) FACILITY AND HOSPICE CONTRACT. The hospice must make payment to the intermediate care facility for individuals with developmental disabilities (ICF/DD) facility for the client's board and room according to the contract between the facility and the hospice.

007.04(B)(ii) PER DIEM LIMITATION. The provider must not bill Medicaid for any provider service related to the terminal illness that is included in the Medicare hospice benefit or services covered under the Medicaid intermediate care facility for individuals with developmental disabilities (ICF/DD) per diem.

007.04(B)(iii) CHILD LIMITATION. Nebraska Medicaid does not pay the hospice for the client's board and room expense in the intermediate care facility for individuals with developmental disabilities (ICF/DD) if the client is a child.