CHAPTER 31-000 SERVICES IN INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR'S)

31-001 Standards for Participation: Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that -

1. Is primarily for the diagnosis, treatment, or habilitation of persons with mental retardation or persons with related conditions; and
2. Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health and habilitative services to help each individual function at his greatest ability.

To participate in the Nebraska Medical Assistance Program (NMAP), an ICF/MR must -

1. Be licensed as a hospital or an ICF/MR by the Nebraska Department of Health and Human Services Regulation and Licensure or, for an out-of-state facility, meet that state's licensure requirements;
2. Meet all related requirements for participation in Medicaid as required by state and federal law and regulation;
3. Be certified as a Title XIX ICF/MR by the Nebraska Department of Health and Human Services Regulation and Licensure or, for an out-of-state facility, by that state's survey agency;
4. Provides licensed nurses sufficient to care for clients' health needs, as defined in 42 CFR 483.460(c) and (d);
5. Provide active treatment as defined in 471 NAC 31-001.02 and 42 CFR 435.1009, and 483.410 - 483.470; and
6. Have a current NMAP provider agreement with the Department.

31-001.01 Legal Basis: Medicaid was established under Title XIX of the Social Security Act. The Nebraska Legislature established the Nebraska Medical Assistance Program under Sections 68-1018 and 1021, R.R.S., 1943.

31-001.02 Definitions: The following definitions apply to ICF/MR services.

Active Treatment: A continuous treatment process which requires -

1. A preadmission evaluation;
2. An individual program plan (IPP);
3. A discharge plan;
4. The client's continuous participation from the time of admission in training and services that meet the requirements of 42 CFR 483.440(a);
5. Training and services to meet the client's needs that are a barrier to a less restrictive alternative (see 42 CFR 456.371);
6. Review and revision of the IPP by the IDT as needed, but at least quarterly; and
7. An annual reevaluation of the client's needs by the interdisciplinary team.

Admission Date: A date on or after which both of the following conditions are met:

1. The interdisciplinary team has determined that the client's needs can be met at the ICF/MR; and
2. The client is physically present in the ICF/MR in an ICF/MR certified bed and is receiving ICF/MR services.

Alternate Levels of Care: Non-institutional living arrangements providing less care than NF or ICF/MR and more care than independent living, such as adult family home, domiciliary facility, residential care facility, group home for children, center for the developmentally disabled, or other community living situations. Also see 469 NAC 3-004.01A ff.

Annual Onsite Review: A health and habilitative review of clients receiving Medicaid conducted at least once a year by the ICF/MR review team in each ICF/MR participating in the Nebraska Medical Assistance Program.

Appropriate: That which best meets the client's needs in the least restrictive alternative.

Bedholding: Full per diem payment made to an ICF/MR to hold a bed when a client is hospitalized or on therapeutic leave.

Central Office means the Medicaid Division in the Department of Health and Human Services Finance and Support and other staff in the Department of Health and Human Services to whom administration of ICF/MR services for the Medicaid program has been delegated. This does not include the central office of the Developmental Disabilities System.

Child: An individual under age 21.

Client: An individual who has been determined eligible for the Nebraska Medicaid Program.

Community-Based Developmental Disability Services (CBDDS): An array of specialized services, including vocational, pre-vocational, residential, and case management, provided outside an institutional setting.

Comprehensive Functional Assessments: A report or a series of reports synthesizing the results of relevant evaluations of the client's abilities and deficits to determine needs.

DDD LFO: The Department of Health and Human Services' Developmental Disabilities Division, Local Field Office Service Coordination.

Department: The Department of Health and Human Services Finance and Support and other staff in the Department of Health and Human Services to whom administration of ICF/MR services for the Medicaid program has been delegated.

Discharge Plan: A plan developed by the ICF/MR's interdisciplinary team (IDT) at the time of admission as part of the Individual Program Plan, reviewed quarterly and revised as needed, which identifies -

1. The rationale for the client's current level of care;
2. The types of services the client would require in a less restrictive alternative; and
3. A summary of alternatives explored for the client through DPI's DDD LFO over the past year. (42 CFR 456.380)

Habilitative Training: Training in new skills and behaviors necessary to facilitate independent functioning.

ICF/MR Review Team: A Central Office team consisting of a registered nurse and a QMRP and, if necessary, one or more of the following:

1. A physician;
2. A social worker; or
3. Other professional personnel as necessary.

Independent QMRP Assessment: A functional evaluation to determine the client's present skills with recommendations for training and/or services. It is conducted by an individual who has been recognized as meeting the established criteria for an QMRP and who is independent of the admitting ICF/MR.

Individual Program Plan (IPP): A written outline of training programs and services that is developed on the basis of functional assessments by the Interdisciplinary Team. The IPP must include discharge plans.

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 appropriate education. The development of the IEP is the responsibility of the child's local school district.

Interdisciplinary Team (IDT): A group of persons representing the professions, disciplines, or service areas that are relevant to identifying the client's needs, coordinating and designing training programs and services to meet these needs. Team membership varies according to individual needs, but must always include a qualified mental retardation professional (QMRP) and a person(s) responsible to assure the client's rights are protected. The IDT must include the client and/or the client's representative, i.e., parents, legal guardian.

Intermediate Care Facility for the Mentally Retarded and Persons with Related Conditions (ICF/MR): A facility or a distinct part of a facility that meets all the standards for participation as in 471 NAC 31-001.

Least Restrictive Alternative: The most appropriate living environment which meets the client's needs in the most normalizing manner.

Level of Care: A category of living arrangement. Levels of care funded by NMAP include NF, ICF/MR, Acute Hospital, and Institution for Mental Disease (IMD).

Local Office: The local HHS office that is responsible for the client's case.

Local School District: Local education agency that, by law, must provide educational services for resident children with disabilities from date of diagnosis to age 21.

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

Medicaid: Medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

Medicaid-Eligible: The status of an individual whom the Department has determined to meet established standards to receive benefits of NMAP.

Medical Care Plan: Physician's plan of care.

Mental Retardation: Significantly subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period as defined in Classification in Mental Retardation (1983), published by the American Association on Mental Retardation. Degrees of mental retardation are mild, moderate, severe, or profound. This definition is consistent with terms in the ICD-10-CM.

NMAP: The Nebraska Medical Assistance Program (Nebraska's Medicaid program).

Need Level: A classification system which identifies clients as high need, moderate need, or low need, which is -

1. Based on the amount of staff time required to meet the client's needs; and
2. Determined by ICF/MR staff.

Normalization Principle: The patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society, taking into consideration possible local and subcultural differences.

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

1. Meets the standards for hospital, skilled nursing, nursing facility, or intermediate facility licensure established by the Nebraska Department of Health and Human Services Regulation and Licensure and all related requirements for participation as prescribed in federal law and regulations governing medical assistance under Title XIX of the Social Security Act;
2. Is certified as a Title XIX NF under Medicaid (may also be certified as a Title XVIII SNF under Medicare);
3. Provides 24-hour, seven-day week RN and/or LPN services (full-time R.N. on day shift) unless the Nebraska Department of Health and Human Services Regulation and Licensure has issued a staffing waiver (see definition of "waivered facility" in 471 NAC 12-001.04); and
4. Has a current NMAP provider agreement and a Certification and Transmittal (Form CMS-1539) on file with the Department.

Physician's Certification (Form DM-5): Physician's determination that the client requires the ICF/MR level of care.

Plan of Care: See "Individual Program Plan".

Preadmission Evaluation: An interdisciplinary process to determine -

1. Specific needs of the client;
2. The least restrictive alternative that meets the client's needs;
3. Availability of the least restrictive alternative;
4. The ICF/MR's ability to meet the client's needs; and
5. If admitted, a written plan of services for the first 30 days.

This process results in the ICF/MR's decision on admitting the client.

Postadmission Evaluation: The individual program plan developed within 30 days of admission (42 CFR 483.440(c)(3)).

Prior Authorization: Determination of necessity for ICF/MR level of care and authorization for payment.

Qualified Mental Retardation Professional (QMRP): An individual who meets the established criteria, based on the purpose.

For QMRP's for Independent Assessments, see 471 NAC 31-002 03 ff.;
For QMRP's in ICF/MR's, see 42 CFR 483.430; and
For QMRP's as administrator, see Department of Health, Bureau of Health Facility Standards.

Related Condition: A severe, chronic disability that meets all of the following conditions:

1. It is attributable to -
   a. Cerebral palsy or epilepsy; or
   b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons;
2. It is manifested before the person reaches age 22;
3. It is likely to continue indefinitely;
4. In the case of a child under three years of age, results in at least one developmental delay;
5. 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:
   a. Self-care;
   b. Understanding and use of language;
   c. Learning;
   d. Mobility;
   e. Self-direction; or
   f. Capacity for independent living; and
6. 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.

Substantial Functional Limitation: A demonstrated interference in the capacity or ability to perform activities appropriate for an individual of comparable chronological age.

Utilization Review: Medicaid-eligible individuals in a facility are reviewed six months after the annual on-site review by the Department's ICF/MR review team to determine whether the ICF/MR level of care is still needed by each individual in accordance with 42 CFR 456, Subpart F.

31-001.03 Summary of Forms: The following forms are used for ICF/MR services under the Nebraska Medical Assistance Program. Instructions for these forms are located in the appendix.

Form #	Form Title	Appendix Reference
DM-5	Physician's Confidential Report	471-000-2
DM-5-MR-LTC	Long Term Care Evaluation for Intermediate Care Facility for the Mentally Retarded	471-000-5
DM-11	Annual Review - Census Sheet	471-000-30
DM-27C	Recommendation for Change of Care Classification or Services (Local Office Notification)	471-000-12
DM-27M	Long Term Care Facility Utilization Review Minutes	471-000-13
DM-27MR-S	ICF/MR Annual Onsite Review Summary Report	471-000-19
DM-28-MR	Intermediate Care Facility for the Mentally Retarded Utilization Review	471-000-16

Form #	Form Title	Reference
FA-66	Report of Long Term Care Facilities for Reimbursement	471-000-41
IM-8	Notice of Finding	471-000-68
MC-4	Long Term Care Facility Turnaround Billing Document	471-000-82
MC-9-NF	Prior Authorization for Nursing Facility Care	471-000-203
MC-10	Prior Authorization Document Adjustment	471-000-211
MC-81	Medical Assistance Long Term Care Provider Agreement	471-000-104
MCP-248	Remittance Advice	471-000-85
MCP-524	Electronic Claims Activity Report	471-000-85
PDS-38	Nebraska Medicaid Card	471-000-123
PDS-38B	Nebraska Health Connection ID Document	471-000-121
	Health Care Claim: Institutional Transaction (ASC X12N 837)	471-000-49
	Health Care Claim Status Request and Response Transaction (ASC X12N 276/277)	471-000-50
	Health Care Eligibility Benefit Inquiry and Response Transaction (ASC X12N 270/271)	471-000-50
	Health Care Services Review – Request for Review And Response Transaction (ASC X12N 278)	471-000-50

31-002 Roles of State Agencies: The Nebraska Department of Health and Human Services Finance and Support (hereafter referred to as the Department) is the single state agency responsible for administering the Medicaid program in Nebraska. The Department has an agreement with the Department of Health and Human Services Regulation and Licensure that designates it as the state survey agency which surveys all long term care facilities in Nebraska to determine if they meet the requirements for participating in NMAP.

31-002.01 Role of the Department of Health and Human Services Regulation and Licensure: The Department of Health and Human Services Regulation and Licensure is responsible for ensuring that each ICF/MR meets state and federal requirements by -

1. Licensing and certifying ICF/MR's;
2. Investigating complaints related to licensure or certification; and
3. Referring appropriate complaints to Adult Protective Services and Child Protective Services.

31-002.02 Role of Department of Health and Human Services Finance and Support: The Department and designated staff in the Department of Health and Human Services are responsible for -

1. Ensuring that each client is -
   a. Receiving services in the least restrictive environment;
   b. Receiving services appropriate for his/her needs; and
   c. Benefiting from Active Treatment;
2. Authorizing payment for ICF/MR services for clients;
3. Reviewing the services each client is receiving;
4. Issuing provider agreements;
5. Setting rates of payment for ICF/MR's;
6. Conducting provider hearings (see 471 NAC 2-003 ff.) and client appeals (see 465 NAC 2-001.02 and 2-006 ff.);
7. Investigating Adult Protective Services and Child Protective Services complaints; and
8. Approving individuals who conduct independent QMRP assessments.

31-002.03 QMRP Approval Criteria: Under 42 CFR 483.430, a qualified mental retardation professional is a person who has at least one year of experience working directly with persons with mental retardation or related conditions and is one of the following:

1. A doctor of medicine or osteopathy;
2. A registered nurse;
3. An individual who holds at least a bachelor's degree or is licensed, certified, or registered and provides professional services in Nebraska in one of the following professional categories:
   a. An occupational therapist;
   b. A physical therapist;
   c. A psychologist;
   d. A social worker;
   e. A speech-language pathologist or audiologist;
   f. A professional recreation staff member;
   g. A professional dietitian; or
   h. A human services professional.

The Department uses these standards to approve individuals who conduct independent QMRP assessments.

31-002.03A Standards for a QMRP: To be approved by the Department to complete Independent QMRP Assessments, an individual shall submit the following information to the Department:

1. Proof of QMRP designation by an outside agency or program; or
2. Verification of -
   a. Education/degree (transcript);
   b. Licensure, registration, or certification, as applicable to the profession (copy); and
   c. One year's experience in working directly with persons with mental retardation. The individual shall indicate the following skills related to his/her job experience in a mental retardation facility/program:
      (1) Assessing the need for specific goals and objectives;
      (2) Writing behaviorally-stated goals and objectives in training programs;
      (3) Conducting or carrying out training programs; and
      (4) Evaluating, documenting, and summarizing training programs.

Department staff shall review the submitted information and, if approved, shall issue a formal letter of approval to the applicant.

The Department may withdraw approval of any QMRP who has been advised by the Department that his/her assessments are lacking in quality and/or completeness.

31-002.03B Independent QMRP Assessment in ICF/MR: Before or at admission, a client with a diagnosis of mental retardation or a related condition, as confirmed by psychological testing, who is seeking admission to an ICF/MR shall have an initial independent QMRP assessment. The current IEP can be accepted as part of the independent QMRP assessment, but does not generally supply all the information required for an independent QMRP assessment or program plan. A program plan from a previous mental retardation service/agency may be substituted for the independent QMRP assessment. The independent QMRP assessment or program plan must have been developed within one year before the admission and must be consistent with current needs.

31-002.03C Requirements for Conducting an Independent QMRP Assessment: The QMRP shall meet the following requirements to conduct an independent QMRP assessment:

1. The individual must be approved as a QMRP in writing by the Department;
2. A QMRP shall not conduct an independent assessment in any facility in which s/he is employed or acts as a consultant at the time of the assessment;
3. The facility is responsible for securing independent QMRP assessments;
4. Payment for the QMRP assessment is the facility's responsibility;
5. The QMRP shall send a written report of the assessment to the facility and a copy of the assessment directly to the ICF/MR review team;
6. The purpose of a QMRP assessment is to identify the present skill levels of the client, recommend training and/or services which the individual needs, and assist the facility in initiating services that are appropriate for the client. The assessment is not an intelligence test to determine the level of functioning. The assessment is considered by the ICF/MR review team in determining a level of care which is appropriate to meet the needs of the client;
7. QMRP assessments must be specific. Terminology such as "appropriately placed" or "ICF/MR" are not acceptable because these terms designate a level of care. Terminology such as "adequate grooming" or "has some behavior problems" are not acceptable because these terms are open to subjective interpretation and do not assist the facility in providing appropriate training and services to the individual; and
8. The QMRP shall sign the assessment. The QMRP assessment becomes a part of the individual's record.

31-002.03D Components of the QMRP Assessment Process: The QMRP shall -

1. Conduct a review of relevant information and records of the client which are available including, but not limited to -
   a. Past QMRP assessments;
   b. Plan of care;
   c. The physician's certification;
   d. Annual physical exams;
   e. Social history;
   f. Social services and activity plans of care;
   g. Past psychological evaluations; and
   h. Other available information;
2. Review records to clarify the client's diagnosis, including -
   a. Evidence of past psychological evaluations regarding the diagnosis of mental retardation. (Is there one? Is there any indication the client had testing in a prior residential setting? Is there any indication that the diagnosis of mental retardation may be inaccurate?);
   b. Evidence of a diagnosis of a related condition, such as epilepsy, cerebral palsy, or autism that occurred before the age of 22;
3. Conduct a functional and complete assessment of skills, using an appropriate standardized assessment tool, to identify the client's present skills and skill-deficit areas in which training and services will benefit the individual; and
4. Interact with and observe the client within his/her environment.

31-002.03E Components of the Written QMRP Assessment: The written QMRP assessment must contain -

1. Identifying information which includes -
   a. Name of the client being assessed;
   b. Date of birth and age of the client;
   c. Address and place of residence of the client;
   d. Diagnosis and physical disabilities based on the record review;
   e. Sources of information;
   f. Assessment tools used and raw scores (from form); and
   g. Signature and address of the QMRP;

2. The narrative which includes -
   a. Identification of abilities and deficits in the following skill areas:
      (1) Self-care: eating, dressing, toileting, grooming, adaptive devices, bathing, care of room, knowledge of personal health needs (i.e., what medications does the client take and what could the client do to meet his/her own health needs). Note: Take into consideration situations, such as all individuals in nursing homes receive supervision with bathing but the degree of supervision varies with the individual's abilities;
      (2) Expressive and receptive language: verbal, gestural, written, and other forms of communication, hearing, speech, and initiation of communication skills;
      (3) Learning: past educational and training experiences, visual deficits or possible learning disabilities, cognitive skills (identification of objects, colors, numbers, alphabet, reading, etc.), and identification of progress in past training (based on previous assessments by QMRP's and through different services);
      (4) Mobility: motor skills, ambulation, locomotion, assistive devices, access to community activities, access to facility activities, and travel within the facility and within the community;
      (5) Self-direction: orientation, socialization skills, inappropriate or maladaptive behaviors, initiation of interactions, leisure-time skills (independently and in structured activities), decision-making skills, involvement in facility and community services and activities, involvement with the family, involvement with friends and peers within the facility and in the community, and need for an advocate, conservator, or guardian;
      (6) Capacity for independent living based on past history, prior services, prior attempts at independent living: food preparation skills, home management skills, laundry skills, money-handling skills, shopping skills, and special needs (health-related, i.e., adaptive devicing, accessibility, health needs which would require attention), socialization skills, and community orientation; and
      (7) Economic self-sufficiency: vocational skills, past vocational experience, and work-related skills;
   b. The QMRP's impressions from interactions with and observations of the client which are identified in the appropriate skill area. The QMRP shall designate which information was acquired from the client; and
   c. A summary of progress, or lack of progress, in previous services;

3. Recommendations which include -
   a. Appropriate referrals for services to meet the client's needs without regard to actual availability of the services, keeping in mind the least restrictive alternatives and the principles of normalization. The recommendations should only address the adequacy of the past and current situations to meet the client's needs; and not identify that the client must go to a specific place;
   b. Referrals for further evaluations as needed, such as clarification of the diagnosis, evaluations of hearing, speech, motor skills, vocational, and other skill areas;
   c. Identification of training and treatments from which the client may benefit and which may be incorporated into the client's plan of care/IPP; and
   d. Priorities for referral needs and training programs to enable the facility to systematically incorporate the QMRP recommendations into the client's plan of care/IPP.

31-003 Admission Process: Individuals seeking Medicaid payment for ICF/MR services shall contact the local office worker. The local office worker must be contacted before the ICF/MR initiates the preadmission evaluation process. The local office worker shall contact the Disability Services Specialist regarding the proposed admission.

31-003.01 ICF/MR Action on Referral: Each ICF/MR has its own policies and procedures for admissions. When an ICF/MR receives a referral, ICF/MR staff shall identify whether the individual has been determined Medicaid-eligible or has applied for Medicaid. For Medicaid-eligible clients, ICF/MR staff shall notify in writing the client's local office worker within three working days of the request for admission. The ICF/MR shall -

1. Gather sufficient information about the client's needs to determine what specific services are required. Information may be gathered from the client, parent(s), and/or guardian; NDSS staff; the client's physician; or other agencies or parties involved with the individual. ICF/MR staff shall obtain a completed Form ASD-46 or a facility form to obtain/release confidential information. The client's rights to confidentiality must be observed. This information includes but is not limited to -
   a. Programs in which the individual is participating or has participated;
   b. A diagnosis of mental retardation or a related condition;
   c. A QMRP assessment or the most recent program plan from a previous MR/DD service/agency, and an IEP, if a school-age child;
   d. Current medical information; and
   e. The client's legal status (e.g., whether the client has a guardian, conservator, payee, power of attorney, etc.); and
2. After sufficient information is gathered, contact the appropriate Developmental Disabilities Division Local Field Office (DDD LFO) regarding the availability of community-based services to meet the individual's need. If there is no response to the initial contact within 14 days, the ICF/MR shall document this and continue with the admission process.

31-003.02 Local Office Worker Action on Referrals: When the local office worker is contacted regarding an ICF/MR admission, the local office worker shall -

1. Document the date of the initial contact and other information, including the name of the contact person at the ICF/MR;
2. Contact the client's other worker(s) (i.e., Social Services Block Grant, Disability Services Specialist, etc.) and share this information with the ICF/MR;
3. Attend the preadmission meeting, if feasible;
4. After all documentation is received, submit the information to the ICF/MR Review Team (see 471 NAC 31-004.03); and
5. Provide additional information on the proposed admission when requested by the ICF/MR review team.

31-003.03 Preadmission Evaluation Process: The ICF/MR shall begin the preadmission process by -

1. Gathering information regarding the client's need for the ICF/MR level of care;
2. Obtaining -
   a. A program plan (IPP) from the previous MR/DD service or agency; or
   b. An independent QMRP assessment if the individual has not been involved with an MR/DD service or agency; and
   c. An IEP for school-age children;
3. Notifying the local office worker and other interested agencies personnel in advance when a preadmission meeting is scheduled; and
4. Submitting all information about the client received during the preadmission process to the local Social Services office.

The evaluations must be conducted within three months before admission or on the date of admission, according to 42 CFR 456.370(a) and (b). Clients who are admitted by the facility must be in need of, be able to benefit from, and receiving active treatment services. Admission decisions must be based on a preadmission evaluation of the client that is conducted by the facility. A preadmission evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, psychological, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

31-003.03A Bedholding During the Preadmission Evaluation: The Department pays for bedholding to the present nursing facility for a maximum of five days while a client is at an ICF/MR for a preadmission evaluation.

31-003.03B Decision Not to Admit: When the ICF/MR staff decide, after the evaluations but before the preadmission meeting, not to admit the client, the ICF/MR staff shall refer the client, parent(s), and/or guardian to any other appropriate alternatives and notify the local office worker of the referrals.

31-003.03C Best Available Plan: The ICF/MR's interdisciplinary team (IDT) shall acknowledge as inappropriate admissions, clients eligible to receive services provided by other agencies and other levels of care (i.e., foster care, NF care, community-based developmental disability services, other non-Medicaid programs, etc.) until the ICF/MR receives verification from the other agencies/levels of care that their services are not appropriate/available for the client. The best available plan is the least restrictive alternative available for the client.

31-003.03D Preadmission Meeting: The preadmission meeting must be attended by the IDT, and the client, parent(s), and/or guardian. The local office worker and/or other interested agencies' staff may attend the pre-admission meeting. The purpose of the preadmission meeting is to-

1. Summarize in writing the findings from the individual functional assessments;
2. Determine the client's needs without regard to the ICF/MR's ability to meet those needs;
3. Determine the availability of least restrictive alternative services;
4. Determine if the client will be admitted to the ICF/MR; and
5. Determine the preadmission plan if the client is to be admitted (see 471 NAC 31-003.03F).

31-003.03E Decision Not to Admit After Preadmission Meeting: When the ICF/MR staff decide not to admit the client after the preadmission meeting, the ICF/MR staff shall refer the individual, parent(s), and/or guardian to any other appropriate alternatives and notify the local office worker and the DDD LFO of the referrals.

31-003.03F Preadmission Plan: The preadmission plan is the IPP for the first 30 days after the individual is admitted to the ICF/MR. It must -

1. Identify further evaluation and testing;
2. Specify the care and services to be provided for the first 30 days or until the post-admission evaluation is established;
3. Include programs/services to be continued from other programs; and
4. Initiate plans to explore other alternatives on an ongoing basis.

31-003.04 Approval of the ICF/MR Level of Care: The ICF/MR, the local office worker, and the Central Office ICF/MR review team shall follow these procedures to obtain approval of payment for the ICF/MR level of care for a specific client.

31-003.04A ICF/MR Responsibilities: The ICF/MR staff shall -

1. Arrange a physician's examination for the client. The physician's examination must be part of the preadmission evaluation. A physician shall sign and date Form DM-5 with the physician's determination of level of care indicated. The client's needs must be recorded on, or attached to, Form DM-5;
2. Ensure that the client has had a dental examination within 12 months before admission or within one month after the date of admission;
3. Ensure that the client has had a psychological evaluation within three months before admission or at the time of admission;
4. Begin completion of Form DM-5-MR-LTC as instructed in 471-000-5; and
5. Send the following to the local office:
   a. A copy of Form DM-5;
   b. Form DM-5-MR-LTC;
   c. The independent QMRP assessment, or the IPP from the previous mental retardation/developmental disability service/agency and the IEP for school-age children;
   d. A mental health evaluation performed by mental health professionals, i.e., psychiatrist or psychologist, as required by the criteria in 471 NAC 31-003.04D; and
   e. The preadmission evaluation and preadmission plan, including exploration of alternatives.

The ICF/MR may submit the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50).

31-003.04B Local Office Responsibilities: The local office worker shall -

1. Complete the required portion of Form DM-5-MR-LTC;
2. Complete Form MC-9-NF as required; and
3. Send all information to the Central Office ICF/MR review team.

See 471 NAC 31-004 ff.

31-003.04C Central Office ICF/MR Review Team Responsibilities: The Central Office ICF/MR review team must receive the following documentation before making a level of care determination:

1. Form MC-9-NF;
2. A copy of Form DM-5;
3. Form DM-5-MR-LTC;
4. The pre-admission evaluation and preadmission plan;
5. The independent QMRP assessment or IPP from previous MR/DD services/agencies;
6. The IEP for school-age children; and
7. For mental illness diagnosis, a mental health evaluation and report from a mental health professional (i.e., psychologist, psychiatrist).

When the Central Office ICF/MR review team receives all required documentation, the Central Office ICF/MR review team shall -

1. Determine if additional information is needed, and if so, request that information from the local office worker, the Disability Services Specialist, and/or the ICF/MR;
2. Consider all documentation in making a decision on payment for ICF/MR services; and
3. Notify the local office of the decision on payment by sending Form MC-9-NF and Form DM-5-MR-LTC to the local office for distribution to the ICF/MR. The local office shall notify the ICF/MR and the Disability Services Specialist of the decision. The local office shall notify the client, parent, and/or guardian of an adverse decision on Form IM-8.

Within 15 days of receipt of all required and requested documentation, the Central Office ICF/MR review team shall review all submitted documentation and determine whether the ICF/MR level of care is appropriate and will be approved for Medicaid payment based on the level of care criteria in 471 NAC 31-003.04D ff.

The Central Office ICF/MR review team shall not approve payment for the ICF/MR care until all required documentation has been received and reviewed.

31-003.04D ICF/MR Level of Care Criteria: The Department applies the following criteria to determine the appropriateness of ICF/MR services on admission and at each subsequent review:

1. The individual has a diagnosis of mental retardation or a related condition which has been confirmed by prior diagnostic evaluations/standardized tests and sources independent of the ICF/MR; and
2. The individual can benefit from "active treatment" as defined in 42 CFR 483.440(a) and 471 NAC 31-001.02. "Benefit from active treatment" means demonstrable progress in reducing barriers to less restrictive alternatives; and
3. In addition, the following criteria shall apply in situations where -
   a. The individual has a related condition and the independent QMRP assessment identifies that the related condition has resulted in substantial functional limitations in three or more of the following areas of major life activity:
      (1) self-care;
      (2) receptive and expressive language;
      (3) learning;
      (4) mobility;
      (5) self-direction; or
      (6) 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; and/or
   b. A Medicaid-eligible individual has a dual diagnosis of mental retardation or a related condition and a mental illness (i.e., mental retardation and schizophrenia). The mental retardation or related condition has been verified as the primary diagnosis by both an independent QMRP and a mental health professional (i.e., psychologist, psychiatrist); and -
      (1) Historically there is evidence of missed developmental stages, due to mental retardation or a related condition;
      (2) There is remission in the mental illness and/or it does not interfere with intellectual functioning and participation in training programs, i.e., the individual does not have active hallucinations nor exhibit behaviors which are manifestations of mental illness; and
      (3) The diagnosis of mental retardation or related condition takes precedence over the diagnosis of mental illness.

31-003.04D1 Inappropriate Level of Care: The following examples are not appropriate for ICF/MR services according to the criteria in 471 NAC 31-003.04D:

1. Mental illness is the primary barrier to independent living within a normalized environment; or
2. The ICF/MR level of care is not the least restrictive alternative, e.g., the client -
    a. Exhibits skills and needs comparable to those of persons with similar needs living independently or semi-independently in the community;
    b. Exhibits skills and needs comparable to those of persons at NF level of care; or
    c. Is able to function with little supervision or in the absence of a continuous active treatment program.

31-003.04D2 Least Restrictive Alternative: On admission and at each subsequent review, the facility shall ensure that services provided in the ICF/MR are the least restrictive alternative.

31-003.05 Out-of-State ICF/MR Services: Each ICF/MR has its own policies and procedures for admission. Those individuals seeking Medicaid payment for out-of-state ICF/MR services shall contact the appropriate local office worker; all notifications from the Department will be processed through the appropriate local office worker. The following steps must be completed to obtain NMAP payment for out-of-state services:

1. The local office worker shall refer the client to the Disability Services Specialist and contact the Central Office ICF/MR review team when initially contacted;
2. The Central Office ICF/MR review team shall assist the local office worker in obtaining necessary information;
3. The local office worker shall refer the client to all ICF/MR's in Nebraska for admission and request a written response from each ICF/MR;
4. Central Office staff shall ensure that the out-of-state ICF/MR meets the following requirements before payment is approved:
   a. The out-of-state ICF/MR must be certified as an ICF/MR to participate in the Medicaid program in that state; and
   b. The out-of-state ICF/MR must have a current NMAP provider agreement;
5. The ICF/MR review team shall determine if the client meets the ICF/MR level of care criteria in 471 NAC 31-003.04D;
6. The out-of-state ICF/MR and the local office worker shall follow the procedures in 471 NAC 31-003.03 ff., regarding the preadmission evaluation process;
7. After the determination is made, the ICF/MR review team shall notify the local office worker; and
8. The local office worker shall notify the individual, parent(s), and/or guardian, the out-of-state ICF/MR, and the Disability Services Specialist.

The out-of-state ICF/MR shall follow all NMAP regulations regarding facility reviews.

31-003.06 Court Commitments: Payment for court-ordered admissions must be approved through the process described in 471 NAC 31-003 ff.

31-003.07 Private-Pay to Medicaid: When an individual paying privately becomes eligible for Medicaid, the admission process requirements of 471 NAC 31-003 ff. must be met before Medicaid payment is approved.

31-004 Local Office Staff Responsibilities: Local office staff responsibilities during the admission process are included in 471 NAC 31-003 and 471 NAC 31-004.01A through 31-004.04.

31-004.01 Plans for Care and Services AFTER Admission to the ICF/MR: The local office staff shall be responsible for the following:

1. Initially contact the Central Office ICF/MR review team when the local office worker has questions concerning continued placement in an ICF/MR and/or continued ICF/MR level of care.
2. As requested by the ICF/MR, local office staff shall explore alternatives available through DSS programs cooperatively with the client, family/guardian, attending physician, and ICF/MR's Interdisciplinary Team (IDT) based on the client's total needs.
3. To appropriately meet the client's needs in other alternatives, the local office staff must -
    a. Be knowledgeable of HHSS-funded services other than ICF/MR which may be appropriate. This includes but is not limited to information on nursing facility services, personal care aide services, waiver services, home health services, and NMAP's criteria for levels of care.
    b. Assist the ICF/MR's IDT with the client and his/her family/guardian to select the most appropriate alternative.
    c. Assist the ICF/MR's IDT in coordinating arrangements for appropriate services with the DSS Disability Services Specialist and the DPI Developmental Disabilities Division Services Coordinator.
4. Local office staff shall assist and/or advise the client and family/guardian at any time a change in facility is necessary due to changes in the client's mental health, medical, and/or habilitative needs, or when the client desires to transfer to a location closer to a family member.
5. Local office staff shall notify the client and family/guardian of any adverse action by the Department concerning placement and/or funding by use of Form IM-8.

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

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

31-004.02 Prior Authorization Requirements: NMAP shall pay for ICF/MR service only when prior authorized. Each admission must be separately prior authorized.

31-004.02A Admission Form MC-9-NF, "Prior Authorization for Nursing Facility Care": Within 15 days of the date of admission to the ICF/MR or the date eligibility is determined, local office staff shall -

1. Obtain an admission Form MC-9-NF from the ICF/MR and complete section VI;
   Note: If the provider submits the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278), the Central Office shall forward the request to the local office staff who shall complete Form MC-9-NF.

2. Attach the following to Form MC-9-NF:
   a. A copy of Form DM-5 or history and physical;
   b. Form DM-5-MR-LTC; and
   c. All documentation submitted by the facility, i.e., preadmission evaluation; and
3. Submit all the information to the Central Office.

The ICF/MR review team shall determine individual need for the ICF/MR level of care and return the forms to the local office for distribution.

Within ten working days after the ICF/MR review team's determination has been received, local office staff shall distribute all copies of Form MC-9-NF as specified in 471-000-203. For electronic Health Care Services Review – Request for Review and Response transactions, the Department shall send the electronic response notification to the provider.

31-004.02B Time Frame for Physician's Admission History and Physical: When the client is admitted to the ICF/MR, local office staff shall work with facility staff to ensure that -

1. The client has had a physical examination within 48 hours (two working days) after admission unless an examination was performed within thirty days before admission; and
2. The history and physical can be documented on Form DM-5 or Hospital H&P attached to Form DM-5.

31-004.02C Time Frame for Physician's Initial Certification (Form DM-5 or Form MC-9-NF): The physician's certification on Form DM-5 or Form MC-9-NF must be signed within the following time frame:

1. For clients already eligible at the time of admission, Form DM-5 or Form MC-9-NF 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
2. For clients not already determined to be eligible at the time of admission, Form DM-5 or Form MC-9-NF 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.
3. The date that eligibility is determined is defined as the actual date the eligibility determination is made (not necessarily the effective date of medical eligibility). This may be the date the worker obtains enough information to make a determination, etc.

If Form DM-5 or Form MC-9-NF is signed and dated more than 30 days before the date of eligibility determination, the facility shall provide the local office worker with a new or updated Form DM-5 or Form MC-9-NF before the Department authorizes payment to the facility.

If Form DM-5 or Form MC-9-NF 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 or Form MC-9-NF is signed and dated. Holidays and weekends are not counted if they fall within the 48-hour time period.

If the date of Form DM-5 or Form MC-9-NF falls within the required time frame, the Department may authorize payment to be effective on the date of admission or the medical eligibility effective date.

4. Form DM-5 must be signed and dated by a physician (if a physician signature stamp is used, the physician shall initial the stamped signature). Physician's assistant or registered nurse signature or initials are not acceptable; and
5. Form DM-5 is maintained in the medical record in the facility where the client resides.

   Form MC-9-NF may be maintained in the client's medical record in the facility where the resident resides, or in the patient account file in the business office.

31-004.02D Distribution of Form DM-5: Form DM-5 must be distributed as follows:

1. The ICF/MR retains the original Form DM-5 for the client's record and sends two copies to the local office;
2. Local office staff retain a copy in the client's case record; and
3. Local office staff send a copy to the Central Office.

31-004.02E Distribution of Form MC-9-NF: Form MC-9-NF must be distributed as follows:

1. The ICF/MR completes Form MC-9-NF and sends it intact with an attached history and physical and a current medication/treatment sheet to the local office;
2. Local office staff completes section VI of the MC-9-NF and retains copies in the client case record; and
3. Local office staff send the MC-9-NF intact with attachments to the Central Office.

31-004.03 Facility-to-Facility Transfer: When a Medicaid client is transferred from one facility to another (NF or ICF/MR), the local office worker shall complete Form MC-10 to close the prior authorization for the previous facility for the date of the transfer.

The local office worker shall follow the appropriate procedures for the new facility.

31-004.04 Inappropriate Level of Care: If the Central Office ICF/MR review team determines that the client's present level of care is inappropriate, the team shall refer the case to the client's local office and the Disability Services Specialist for a change to the appropriate level of care. Local office staff shall notify the client, parent(s), and/or guardian on Form IM-8. If the parents or guardian choose, they may notify the DDD LFO. Local office staff shall complete Form MC-10 to notify the Central Office ICF/MR review team.

For those clients who, at the time of initial review, are found to be inappropriate for ICF/MR care, the Department shall limit Medicaid payment for up to a maximum of 30 days, beginning with the date the ICF/MR review team determines that the level of care is inappropriate.

31-004.05 Requests for Change in Level of Care

31-004.05A ICF/MR Requests: ICF/MR staff shall submit requests for a change of level of care between reviews to the Central Office ICF/MR review team in writing along with supporting documentation. When an ICF/MR's request for a change in a client's level of care is approved, local office staff shall complete Form MC-10 to close the authorization for the previous ICF/MR.

31-004.05B ICF/MR Review Team Recommendation: When the Central Office ICF/MR review team recommends a change in level of care after reviewing the client's health and habilitative training needs, based on the ICF/MR level of care criteria in 471 NAC 31-003.04D ff.:

1. The Central Office ICF/MR review team shall send a notification letter to the client's attending physician and the ICF/MR's QMRP, giving them an opportunity to respond, and -
   a. If appropriate justification for continued ICF/MR care is provided within the time frames specified in the letter of notification, the recommendation may be withdrawn; or
   b. In the absence of appropriate and timely justification, the recommendation becomes final;
2. The Central Office ICF/MR review team shall send a notification to the ICF/MR and the local office on -
   a. Form DM-27MR-S, "ICF/MR Annual Onsite Review Summary Report;"
   b. A letter to the physician; and
   c. A letter to the ICF/MR's QMRP; and
3. Transfers of Medicaid-eligible clients must be completed in compliance with 471 NAC 31-004.03.

31-004.06 Procedures for Deinstitutionalization: When the Central Office ICF/MR review team recommends deinstitutionalization after reviewing the client's health, habilitative, and social needs, based on the ICF/MR level of care criteria in 471 NAC 31-003.04D:

1. The Central Office ICF/MR review team shall send a notification letter to the client's attending physician and the ICF/MR's QMRP giving them an opportunity to respond, and -
   a. If appropriate justification for continued ICF/MR care is provided within the time frames specified in the letter of notification, the recommendation may be withdrawn; or
   b. In the absence of appropriate and timely justification, the recommendation becomes final;
2. The Central Office ICF/MR review team shall notify the ICF/MR by -
   a. Form DM-27 MR-S, "Annual Summary Report;"
   b. A letter to the physician; and
   c. A letter to the ICF/MR's QMRP.
3. Upon receipt, the ICF/MR shall document a specific and appropriate discharge plan in compliance with 42 CFR 483.440(b) to assist the client in preparing for alternate arrangements;
4. The Central Office ICF/MR review team shall notify the client's local office; and
5. NMAP payment for ICF/MR care is approved for up to 60 days from the date the client's local office is notified. During this time, local office staff shall -
   a. Notify the client, parent(s), and/or guardian on Form IM-8. If the parents or guardian choose, they may notify the DDD LFO; and
   b. Assist with making alternate arrangements, if requested.

31-005 Responsibilities of ICF/MR's: All ICF/MR's shall provide staff of the federal Department of Health and Human Services, and HHSS Central Office, district, and local offices 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 the Nebraska Department of Health and Human Services Finance and Support Manual, federal Medicaid regulations, and program instructions.

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

31-005.01 Referral: The ICF/MR shall contact the client's local office worker when initial contact regarding admission is made within three working days of the request for admission.

31-005.02 Discipline Evaluations: Before admission to an ICF/MR or before authorization of payment, an interdisciplinary team of professionals make a comprehensive medical, social, and psychological evaluation of each client's needs for care in the ICF/MR as specified in 471 NAC 31-003.04.

31-005.03 Admission Notification: At the time of admission or no later than 48 hours (two working days) after the preadmission meeting, the ICF/MR shall notify the client's local office of the admission decision.

31-005.04 Initial Certification: The ICF/MR shall ensure that -

1. A physician signs and dates Form DM-5 with the date within the time frames identified in 471 NAC 31-004.02C;
2. Form DM-5 must be signed and dated by a physician (if a physician signature stamp is used, the physician shall initial the stamped signature). Physician's assistant or registered nurse signature or initials are not acceptable; and
3. Form DM-5 is maintained in the client's medical record in the facility where the client resides.

31-005.04A Admission Form DM-5-MR-LTC: Within 15 days of the date of admission to the ICF/MR or the date eligibility is determined, facility staff shall submit the following to the client's local office -

1. An admission Form DM-5-MR-LTC completed as required by 471-000-5;
2. A copy of Form DM-5;
3. A copy of the preadmission evaluation and plan, QMRP assessment or previous program plan, and the IEP for school-age children;
4. A copy of the mental health evaluation;
5. The entire Form MC-9NF or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see electronic Standard Electronic Transaction Instructions at 471-000-50); and
6. Submit all the information to the Central Office ICF/MR review team.

The Central Office ICF/MR review team shall determine the appropriateness of the level of care and return the forms to the local office for distribution. Within ten working days after the ICF/MR review team's determination has been received, local office staff shall distribute the forms as indicated in 471-000-5 and 471-000-203. For electronic Health Care Services Review – Request for Review and Response transactions, the Department shall send the electronic response notification to the provider.

31-005.05 Annual Physical Examination: The Department requires that all individuals eligible for Medicaid residing in long term care facilities have an annual physical examination. The physician, based on his/her 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 will be reimbursed based on the physician's orders. The results of the examination must be recorded in the individual's medical record.

31-005.05A Billing for the Annual Physical Examination: If the annual physical examination is performed solely to meet the Medicaid requirement, the physician shall shall use the appropriate HCPCS code and submit the claim to the Department on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49). If the physical examination is performed for diagnosis and/or treatment of a specific symptom, illness, or injury and the individual has Medicare or other third party coverage, the physician shall submit the claim through the usual Medicare or other third party process.

31-005.06 Health Care Services: The ICF/MR shall ensure that ICF/MR 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.

31-005.06A Physician Services

31-005.06A1 Physician's Overall Plan of Care: Before admission to an ICF/MR or before authorization for payment, a physician shall establish a written plan of care for each client. The plan of care must include -

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the client;
3. Objectives;
4. Any orders for -
    a. Medications;
    b. Treatments;
    c. Restorative and rehabilitative services;
    d. Activities;
    e. Therapies;
    f. Social Services;
    g. Diet; and
    h. Special procedures designed to meet the objectives of the plan of care;
5. Plans for continuing care, including review of and modification of the plan or care;
6. A determination of whether the client needs a medical care plan; and
7. Plans for discharge.

The physician must review each client's plan of care at least every 90 days.

31-005.06A2 Standards for Physician Services: The facility shall 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.

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:

1. Evaluation of vision and hearing;
2. 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;
3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed;
4. 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.

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.

31-005.06A3 Physician Participation in the Individual Program Plan: A physician shall participate in -

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

31-005.06A4 Recertification: The physician or the physician's assistant shall recertify in writing the client's continued need for the ICF/MR 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 ICF/MR. The interdisciplinary team responsible for the client's care determines the client's length of stay.

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.

The physician, the physician's assistant, or nurse practitioner shall sign, or stamp and initial, and date the recertification clearly identifying himself/herself as a physician, physician's assistant, or nurse practitioner.

Facility staff shall maintain the recertification in the client's medical record in the facility where the client resides.

The physician shall record recertifications accomplished by on-site visits to the facility in the client's medical record. The physician is paid according to 471 NAC 18-006 ff. for a nursing home visit. The physician shall use the appropriate procedure codes when billing NMAP for this service.

31-005.06B Nursing Services

31-005.06B1 Standards for Nursing Services: The facility must provide clients with nursing services in accordance with their needs. These services must include -

1. Participation in the preadmission evaluation and in the development, review, and update of an individual program plan as part of the IDT process;
2. 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;
3. For those clients certified as not needing a medical care plan, a review of their health status which must -
   a. Be by direct physical examination;
   b. Be by a licensed nurse;
   c. Be on a quarterly or more frequent basis depending on need;
   d. Be recorded in the record; and
   e. Result in any necessary action (including referral to a physician to address health problems;
4. Other nursing care as prescribed by the physician or as identified by needs;
5. Implementing, with other members of the IDT, appropriate protective and preventive health measures that include, but are not limited to -
   a. Training clients and staff as needed in appropriate health and hygiene methods;
   b. Control of communicable diseases and infections, including the instructions of other personnel in methods of infection control; and
   c. 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.

The nursing plan of care as part of the IPP must be revised as necessary, but reviewed at least quarterly.

31-005.06B2 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 clients' health needs including those clients with medical care plans.

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.

31-005.06C Dental Care: All ICF/MR clients must have a dental evaluation -

1. Within 12 months before admission or within one month after admission; and
2. At least annually thereafter.

Dental services must be provided in accordance with 471 NAC 6-000 to be covered by NMAP.

31-005.06C1 Standards for Dental Services: The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including 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 IDT process either in person or through written report to the IDT. The facility must provide education and training in the maintenance of oral health.

31-005.06C2 Comprehensive Dental Diagnostic Services: Comprehensive dental diagnostic services include -

1. 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);
2. Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease; and
3. A review of the results of examination and entry of the results in the client's dental record.

31-005.06C3 Comprehensive Dental Treatment: The facility must ensure comprehensive dental treatment services that include -

1. The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and
2. Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

31-005.08C4 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.

31-005.07 Interdisciplinary Team (IDT) Responsibilities: As soon as the 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 IPP. The 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.

Long term goals and short term objectives for all formal training to be provided are based on identified needs. Objectives must be -

1. Person-centered;
2. Stated in specific, observable, and measurable terms so that the level of skill acquisition can be assessed;

The long term goal must be the culmination of its short term objectives.

A copy of each client's IPP, functional assessments, and nursing plan of care must be made available to all relevant staff and IDT.

The IDT must revise each IPP as needed, but review each IPP at least quarterly.

At least annually, the IDT reviews and updates each client's IPP, including ongoing exploration of alternatives. Each IDT member's assessment must be completed before this annual review. The revision in the 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 QMRP and other 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/or if revisions are needed. Revisions must be made in accordance with 471 NAC 31-001.

31-005.08 Facility Responsibilities

31-005.08A Freedom of Choice: Each ICF/MR shall ensure that any client may exercise his/her freedom of choice in obtaining NMAP-covered services from any provider qualified to perform the services (see 471 NAC 1-004.02).

31-005.08B Room and Bed Assignments: ICF/MR staff shall maintain a permanent record of the client's room and bed assignments. This record must show the dates and reasons for all changes in accordance with 42 CFR 442.404, and be maintained in the medical record.

31-005.08C Requests for Change of Level of Case: ICF/MR staff shall submit requests for a change of level of care between reviews to the Central Office ICF/MR review team in writing and notify the client's local office worker in writing.

When the client is discharged, ICF/MR staff shall close the client's case on Form DSS-4 and notify the local office worker.

31-005.08D Facility-to-Facility Transfer: To transfer a client from one facility to another, the transferring ICF/MR shall -

1. Obtain physician's written order for transfer;
2. Obtain written consent from the client, parent(s), and/or guardian;
3. Notify the local office that handles the client's case before the transfer is made in writing, stating -
   a. The reason for transfer;
   b. The name of facility to which the client is being transferred; and
   c. The anticipated date of transfer;
4. Document transfer information in the client's record and discharge summary; and
5. Release necessary information on the client's health and habilitation needs to the admitting facility.

The admitting facility shall obtain a new physician's certification for the current admission.

31-005.08E Discharge Planning: Each ICF/DD shall maintain written discharge planning procedures for all Medicaid clients that describe -

1. Which staff member of the ICF/DD has operational responsibility for discharge planning;
2. The manner in, and methods by, which the staff member will function, including authority and relationship with the ICF/DD's staff;
3. The resources available to the ICF/DD, the client, and the attending physician to assist in developing and implementing individual discharge plans; and
4. The initiation of discharge planning at admission. This must include formal referral of each individual to the DDD LFO and any community-based programs that can meet the individual's needs; and
5. The IDT reevaluates each client's discharge plan at the time of the annual IPP. The IDT shall review at least quarterly and revise as needed.

31-005.08F Active Discharge Planning: If the ICF/DD review team determines the client meets the criteria for ICF/DD but his/her health and habilitative needs could more appropriately be met in another setting (i.e., community-based or NF) -

1. The ICF/DD shall notify the individual, family or legal guardian, local office worker, and the DDD LFO of the recommendation;
2. The ICF/DD shall assist the client, family, or legal guardian, and local office worker in seeking appropriate alternatives.
3. The ICF/DD shall document that other alternatives were explored and the responses;
4. The present ICF/DD shall provide services to meet the needs of the client and shall refer to appropriate agencies for services until an appropriate alternative is available; and
5. The ICF/DD, the local office worker, and others involved shall make available to the ICF/DD review team the documentation of active exploration for appropriate alternatives.

31-005.08G At the Time of Discharge: The ICF/DD shall:

1. Provide any information (e.g. diagnosis, active treatment services, habilitation potential physician advice concerning immediate care, and pertinent social information) about the discharged client that will ensure the optimal continuity of care to those persons responsible for the client's post-discharge care;
2. Discharge the following items specifically purchased for and used by the client with the client:
    a. Any non-standard wheelchair and wheelchair accessories, options, and components, including power operated vehicles;
    b. Any augmentative communicative devices with related equipment and software;
    c. Supports (e.g. trusses and compression stockings with related components); and
    d. Custom fitted and/or fabricated items.

31-005.08H Discharges: Within 48 hours (two working days) after a client is discharged or expires, the ICF/DD shall notify the local office that handles the client's case of -

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

31-005.08J Utilization Review of ICF/MR Clients: ICF/MR classification is approved using the level of care criteria in 471 NAC 31-003.04D ff. The review of clients residing in ICF/MRs is accomplished by the Central Office ICF/MR review team every six months. Within six months after the annual on-site review, but before each scheduled utilization review, the ICF/MR's QMRP's shall complete sections 1, 2, 3, and 4 of Form DM-28MR. The ICF/MR shall retain documentation of the utilization review in the client's permanent record.

31-005.08K Facility Action on Annual Summary Report (Form DS-27MR-S): Within ten days following receipt of the ICF/MR review team's summary report of the annual on-site review, the ICF/MR shall respond to the Central Office in writing, and shall include the following information in the response:

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.

31-005.08K1 Failure to Respond: If the ICF/MR fails to submit a timely and/or appropriate response, the Department may take administrative sanctions (see 471 NAC 2-002 ff.) or any of the following actions:

1. The Department may suspend Title XIX reimbursement for a client or the entire reimbursement for the ICF/MR; or
2. Clients may be transferred to another facility.

31-006 ICF/MR Review Team Responsibilities

31-006.01 Annual Onsite Review: Federal regulations at 42 CFR 456, Subpart I, require annual review of all Medicaid-eligible individuals residing in ICF/MR's for a redetermination of appropriate care level and necessity for services. The annual onsite reviews are accomplished by a review team who -

1. Visits each ICF/MR;
2. Reviews each client's health and habilitative records;
3. Interviews and/or observes each individual and appropriate ICF/MR staff;
4. Completes a written summary report; and
5. Sends copies of the report to -
   a. The ICF/MR;
   b. The Central Office;
   c. The Department of Health and Human Services Regulation and Licensure; and
   d. All local offices, as appropriate, i.e., to notify of changes in client status.

31-006.02 ICF/MR Review Team's Annual Onsite Review Functions: The ICF/MR review team must have a registered nurse and a qualified mental retardation professional (QMRP), and may have any of the following:

1. A physician;
2. A social services reviewer; and
3. Other appropriate health and social services personnel.

31-006.02A Physician: The Medical Director in the Central Office shall serve as the director, consultant, and coordinator and is the final authority for findings, patient care recommendations, and official action.

31-006.02B Registered Nurse: In the annual onsite review at all ICF/MR's, the registered nurse shall -

1. Review the medical records, and document the findings for each client reviewed to determine appropriate level of care based on the client's health and professional nursing care needs, any unmet health and professional nursing care needs which appear indicated, and the ICF/MR's compliance with all Title XIX (Medicaid) regulations;
2. Assess the client's response to care and treatment based upon observation and/or conversation with the client as needed; and
3. Review information and documentation with other team members to make formal recommendations.

31-006.02C Social Services Reviewer or Other Health and Social Services Personnel: In the annual onsite review, when applicable, the reviewer shall, at a minimum, but not limited to -

1. Visit and/or observe each individual eligible for Medicaid and review the social and recreational services to identify possible unmet care needs;
2. Review relevant documentation to determine -
   a. The appropriate level of care based on the client's needs;
   b. Any unmet needs; and
   c. The facility's compliance with all Medicaid regulations;
3. Document findings for each client reviewed;
4. Assess the client's response to services, based on observation and conversation as needed;
5. Review discharge plans; and
6. Share the client's care concerns or recommendations with the other team members to make formal recommendations on needed care adjustments.

31-006.02D Qualified Mental Retardation Professional (QMRP): In the annual on-site review, the QMRP shall -

1. Review the training, habilitative, and all relevant documentation for each client to determine the appropriate level of care based on the client's habilitative training needs, any unmet training and habilitative needs which appear indicated, and the ICF/MR's compliance with all Title XIX (Medicaid) regulations, and document findings for each client reviewed;
2. Assess the client's response to training and habilitation based on classroom/training area observation and/or conversation with the client as needed; and
3. Review all information and documentation with other team members to make formal recommendations.

31-006.02E Summary Report: The ICF/MR review team shall complete a summary report after the onsite review. The summary report is distributed as follows:

1. The Central Office staff shall send the entire report to the ICF/MR;
2. The ICF/MR shall respond, in writing on the form, to NDSS within 10 days after receipt of the summary report. In the response, the ICF/MR shall specify a complete plan of correction for all identified deficiencies, changes in level of care, and recommendations for individuals; and
3. Department staff shall distribute copies of the report and the ICF/MR's corrective action plan to the ICF/MR, the appropriate local social services offices, the ICF/MR review team, Department of Health and Human Services Regulation and Licensure, and if appropriate, the Department of Health and Human Services.

31-006.03 Utilization Review in ICF/MR's: All clients receiving ICF/MR services are reviewed by the ICF/MR review team for continued stay necessity at least every six months. The ICF/MR review team shall -

1. Send Form DM-28-MR for each client to the ICF/MR one month before the scheduled utilization review;
2. Review the client's IPP, and complete Form DM-28MR;
3. Send the facility copy of Form DM-28-MR to the ICF/MR for retention in the client's permanent record;
4. When reclassification is recommended or continued stay is not approved, follow the appropriate procedures (see 471 NAC 31-006.04 or 31-006.05);
5. Complete the UR minutes;
6. Send the minutes to the ICF/MR; and
7. Send copies to the appropriate local social services offices when changes in level of care are made.

The team may interview the client and the ICF/MR's staff.

31-006.03A Composition of the Utilization Review Team: The utilization review team must have a registered nurse, a QMRP, and may have any of the following:

1. A physician;
2. A social services reviewer;
3. Other appropriate health and social services personnel.

31-006.04 Requests for Change in Level of Care

31-006.04A ICF/MR Requests: ICF/MR staff shall submit requests for a change of level of care for a client between reviews to the Central Office ICF/MR review team in writing along with supporting documentation. The ICF/MR review team determinations must be based on the level of care criteria in 471 NAC 31-003.04D ff. When the client transfers, the ICF/MR shall notify the appropriate local office.

31-006.04B ICF/MR Review Team Recommendation: When the Central Office ICF/MR review team recommends a change of level of care after reviewing the client's health and habilitative training needs, based on the ICF/MR level of care criteria in 471 NAC 31-003.04D ff.:

1. The Central Office ICF/MR review team shall send a notification letter to the client's attending physician and the ICF/MR's QMRP, giving them an opportunity to respond, and -
   a. If the physician and QMRP present appropriate justification for continued ICF/MR care within the time frame specified in the letter of notification, the recommendation may be withdrawn;
   b. In the absence of appropriate or timely justification, the recommendation becomes final;
2. The Central Office ICF/MR review team shall send a notification to the ICF/MR and the local office by -
   a. Form DM-27MR-S, "ICF/MR Annual Onsite Review Summary Report;"
   b. A letter to the physician; and
   c. A letter to the ICF/MR's QMRP;
3. Client transfers must be completed in compliance with applicable regulations; and
4. Local office staff shall complete Form MC-10 to change the level of care.

31-006.04C ICF/MR Level of Care Continuance: A client who currently resides in an ICF/MR who has been determined inappropriate for that level of care may be approved by the ICF/MR review team to continue at the ICF/MR level of care for a limited period of time. The continuance may be approved when the ICF/MR presents written documentation of its ongoing efforts to obtain an appropriate alternative living situation for the client.

31-006.05 Procedures for Deinstitutionalization: When the ICF/MR review team recommends deinstitutionalization after reviewing the client's health, habilitative, and social needs, based on the ICF/MR level of care criteria in 471 NAC 31-003.04D ff., the ICF/MR review team shall follow procedures as specified in 471 NAC 31-004.06.

31-007 Medicaid Payment Restrictions for ICF/MR: NMAP shall pay for ICF/MR services only when authorized via Form MC-9-NF or using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50).

31-007.01 Initial Certification: The Department shall approve payment to an ICF/MR for services rendered to an eligible client beginning on the date -

1. The client is formally admitted to the ICF/MR following the preadmission evaluation process (see 471 NAC 31-003.04 ff.);
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.

Note: If Form DM-5 is signed and dated more than 30 days before admission or the date eligibility is determined, the Department shall not approve payment unless a new or updated Form DM-5 is obtained (see 471 NAC 31-004.02C).

31-007.02 Death on Day of Admission: If a client is admitted to an ICF/MR and dies before midnight on the same day, the Department allows payment for one day of care (see 471 NAC 31-008.06B).

31-007.03 Inappropriate Level of Care: If the Central Office ICF/MR review team determines that the client's present level of care is inappropriate, the team shall refer the case to the client's local office and the Disability Services Specialist for a change to the appropriate level of care. Local office staff shall notify the client, parent(s), and/or guardian on Form IM-8. Local office staff shall complete Form MC-10 to notify the Central Office ICF/MR review team and the ICF/MR.

For those clients who, at the time of initial review, are found to be inappropriate for ICF/MR level of care, NDSS shall limit Medicaid payment for up to a maximum of 30 days, beginning with the date of admission or the date the ICF/MR review team determines that the level of care is inappropriate.

31-007.04 Payment for Bed-holding: The Department makes payments to reserve a bed in an ICF/DD 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 habilitative 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 full per diem reimbursement for 15 days per hospitalization;
3. Therapeutic leave bed-holding is limited to full per diem reimbursement for 36 days per calendar year. Bed-holding days are prorated when a client is admitted after January 1;
4. A transfer from one facility to another does not begin a new 36-day period;
5. The individual's IDT must address therapeutic leave in the IPP; and
6. Facility staff shall work with the client, parent(s), and/or guardian to plan the use of the allowed 36 days of therapeutic leave for the calendar year.

31-007.04A Special Limits: When the limitation for therapeutic leave interferes with an approved therapeutic or habilitative program, the ICF/DD may submit a request for special limits of up to an additional six days per calendar year to the Medicaid Division. Requests for special limits must include -

1. The number of leave days requested;
2. The need for additional therapeutic bed-holding days;
3. The physician's orders; and
4. The IPP.

31-007.04B Reporting Bed-holding Days: ICF/DD's shall report bed-holding days on the appropriate claim (see Claim Submission Table at 471-000-49). 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 ICF/DD at 12:00 midnight.

31-007.05 Items Included in Per Diem Rates: The following items are included in the per diem rate:

1. Routine Services: Routine nursing care services include regular room, dietary, and nursing services; social services and active treatment program as required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are -
   a. All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; hand-feeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;

b. Active treatment: The facility shall 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 (see 42 CFR 483.440 and 471 NAC 31-001.02);
c. Items which are furnished routinely and relatively uniformly to all patients, such as patient gowns, linens, water pitchers, basins, bedpans, etc.;
d. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, band-aids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, sanitary napkins and related supplies, etc.), etc.;
e. Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, and their maintenance, etc.;
f. Nutritional supplements and supplies used for oral, enteral, or parenteral, feeding;
g. Laundry services, including personal clothing; and
h. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.

2. Injections: The patient's physician shall prescribe all injections. Payment is not authorized for the administration of injections, since giving injections is considered a part of routine nursing care and covered by the long term care facility's reimbursement. Payment is authorized to the drug provider for drugs used in approved injections. Syringes and needles are necessary medical supplies and are included in the per diem rate.
3. Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility shall provide transportation to client services that are reimbursed by Medicaid (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.

31-007.06 Items Not Included in Per Diem Rates

31-007.06A Payments to ICF/DD SEPARATE from the Per Diem Rate: Items for which payment may be made to ICF/DD providers and are not considered part of the facility's Medicaid per diem rate 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, are considered necessary equipment in an ICF/DD to provide care.
2. Air fluidized bed units and low air loss bed units; and
3. Negative Pressure Wound Therapy.

31-007.06B Payments to Other Providers: Items for which payment may be authorized to non-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, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16);
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses (see 471 NAC 24), hearing aids (see 471 NAC 8), etc.;
3. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7;
4. Prostheses (e.g. breast, eye, lower and upper limb) as defined in 471 NAC 7;
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4.
    a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, Medicaid shall not make payment for ambulance service.
    b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the Nursing Facility and/or ICF/DD).

31-008 Payment for ICF/DD Services

31-008.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447, Subpart C, which provide for payment of ICF/DD services;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state, and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

31-008.02 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 ICF/DDs with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

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

31-008.03 Allowable Costs: The following items are allowable costs under Medicaid.

31-008.03A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

1. Meet the definition in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services, Division of Public Health, the agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing skilled nursing or intermediate care facility, as applicable.

31-008.03B Items Included in Per Diem Rates: The following items are included in the per diem rate:

1. Routine Services: Routine ICF/DD services include regular room, dietary, and nursing services; social services and active treatment program as required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:
   a. All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; hand-feeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
   b. 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 supplies to include but limited to augmentative communication devices with related equipment and software, as described in each client's Individual Plan of Care (see 42 CFR 483.440 and 471 NAC 31-001.02);
   c. Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins, bedpans, etc.;
   d. Items stocked at nursing stations or on each floor/home in gross supply and distributed or used individually, such as 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 (e.g. trusses and compression stocking with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, sanitary napkins and related supplies, etc.), etc.;
   e Items which are used by individual residents but which are reusable and expected to be available: such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, and all other durable medical equipment not listed in 31-007.06B;
   f. Nutritional supplements and supplies used for oral, enteral, or parenteral feeding;
   g. Laundry services, including personal clothing;
   h. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service; and
   i. Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance.
2. 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.

3. 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 (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.

31-008.03C Ancillary Services: Ancillary services are those services which are either provided by or purchased by an ICF/DD and are not properly classified as "routine services." The ICF/DD must contract for ancillary services not readily available in the ICF/DD.

If ancillary services are provided by a licensed provider, e.g., physician, dentist, etc., the provider must submit a separate claim for each client served.

Occupational therapy, physical therapy, speech pathology, audiology, psychological, and resident transportation services are considered routine operating costs for ICF/DDs.

Department-required independent QMRP assessments are considered ancillary services.

31-008.03D Payments to ICF/DD Provider SEPARATE from Per Diem Rates: Items for which payment may be made to ICF/DD 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 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.

31-008.03E Payments to Other Providers: Items for which payment may be authorized to non-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, OTC drugs*, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16). *Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc.;
3. Orthoses (e.g. lower and upper limb, foot and spinal) as defined in 471 NAC 7;

4. Prostheses (e.g. breast, eye, lower and upper limb) as defined in 471 NAC 7;
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4.
    a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, Medicaid does not make payment for ambulance service.
    b. Non-emergency ambulance transports to physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the ICF/DD).

31-008.04 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15;
5. Travel and entertainment, other than for professional meetings and direct operations of the facility. Costs of motor homes, boats, and other recreational vehicles including operation and maintenance are not allowable expenses;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;

11. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state-operated facilities. These exclusions are paid separately;
12. Return on equity;
13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients that are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts. Recreational and therapeutic facilities necessary for the needs of persons with mental retardation in ICF/MR's will be allowed.

31-008.05 Limitations for Rate Determination: The Department applies the following limitations for rate determination to ICF/MRs that are not State-operated.

31-008.05A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

31-008.05B Total Inpatient Days: Total inpatient days are days on which the patient occupies the bed at midnight or the bed is held for hospital leave or therapeutic home visits. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and up to 36 days of therapeutic home visits per calendar year for an ICF/MR client.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document") or the standard electronic 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 not considered Medicaid inpatient days.

Exception: When a client is admitted to an ICF/MR and dies before midnight on the same day, the Department allows payment for one day of care. The day is counted as one Medicaid inpatient day.

31-008.05B1 For ICF/MRs with 16 beds or more: In computing the provider's allowable cost per day for determination of the rate, total inpatient days are the greater of the actual occupancy or 85 percent of total licensed bed days.

31-008.05B2 For ICF/MRs with 4-15 beds: In computing the provider's allowable cost per day for determination of the rate, total inpatient days for fixed costs are the greater of actual inpatient days or 85% of licensed beds. For computing the non-fixed costs per day the actual patient days are utilized.

31-008.05C New Construction, Reopenings, and Certification Changes: For new construction (entire facility or bed additions), facility reopenings, or a certification change from Nursing Facility to ICF/MR total inpatient bed days available are the greater of actual occupancy or 50 percent of total licensed bed days available during the first year of operation, beginning with the first day patients are admitted for care.

31-008.05D Start-Up Costs: All new providers entering NMAP after July 31, 1982, must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months. Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

31-008.05E Customary Charge: The Department does not use HIM-15, Chapter 26 policies and procedures. Average customary charge is defined as net revenue (total charges for covered services reduced by charity and courtesy allowances, bad debts, and other uncollected charges) derived from "private" residents divided by the "private" inpatient days (including applicable bedholding).

Facilities in which private resident days are less than 5 percent of the total inpatient days, as defined in 471 NAC 31-008.05B, will not be subject to the customary charge limitation.

31-008.05E1 ICF/MRs with 16 beds or more: An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.

The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, adjusted by the Inflation Factor (see 471 NAC 31-008.06C7) for the most recent report period.

31-008.05E2 ICF/MRs with 4-15 beds: An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.

31-008.05F Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

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

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

31-008.05G Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 31-008.05J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

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

31-008.05H Interest Expense: For rate periods beginning January 1, 1985, 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 ICF/MR care. This limitation does not apply to government owned facilities.

31-008.05J Recognition of Fixed Cost Basis: The fixed cost basis for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

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

471 NAC 31-008.07E, Recapture of Depreciation, will apply to this part.

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

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

31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

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

ICF/DDs with 4-15 beds are excluded from Certificate of Need requirements.

31-008.05L Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6). See Appendix 471-000-11 for administrator compensation maximums.

For future cost report periods, administrator compensation maximums will be adjusted annually based on inflation factors published in HIM 15, Section 905.6 and will not be specified in the regulations. Once calculated, these maximums will be available for review from the Department and published in Appendix 471-000-11.

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

31-008.05M 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 Personnel Operating and Non-Personnel Operating Cost Components for the facility.

This computation is made by dividing the total allowable Personnel Operating and Non-Personnel Operating Cost Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Personnel Operating and Non-Personnel Operating Cost 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.

31-008.05N Facility Bed Size Exception: Rates for any privately-owned ICF/DD with less than 16 beds that received Medicaid reimbursement prior to July 1, 2009 will be determined based on the methodology described in 471 NAC 31-008.06C for ICF/DDs with 16 or more beds.

31-008.05P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

31-008.06 Rate Determination: The Department determines rates under the following guidelines:

31-008.06A Rate Period: The Rate Period for non-State-operated ICF/DD providers is defined as July 1 through June 30. Rates paid during the Rate Period are determined from cost reports submitted for the Report Period ending June 30 two years prior to the end of the Rate Period (see 471 NAC 31-008.06C1). For example, cost reports submitted for the Report Period ending June 30, 2009 determine rates for the Rate Period July 1, 2010 through June 30, 2011.

The Rate Period for State-Operated ICF/DD providers is defined as July 1 through June 30.

31-008.06B Report Period: Each facility must file a cost report each year for the reporting period ending June 30.

31-008.06C Rates for Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) Excluding State-Operated ICF/DD Providers:

31-008.06C1 ICF/DDs with 16 beds or more: Subject to the allowable, unallowable, and limitation provisions of this system, the Department determines facility-specific prospective per diem rates based on the facility's allowable, reasonable and adequate costs incurred and documented during the Report Period. The rates are based on financial and statistical data submitted by the facilities. Individual facility prospective rates have five components:

1. The ICF/DD Personnel Operating Cost Component adjusted by the inflation factor;
2. The ICF/DD Non-Personnel Operating Cost Component adjusted by the inflation factor;
3. The ICF/DD Fixed Cost Component;
4. The ICF/DD Ancillary Cost Component adjusted by the inflation factor; and
5. The ICF/DD Revenue Tax Cost Component.

An ICF/DD facility's prospective rate is the sum of the five components.

31-008.06C1a Durable Medical Equipment (DME) Rate Add-On: Effective August 1, 2013, facilities are responsible for costs of certain durable medical equipment. To account for these increased costs:

1. For the rate period August 1, 2013 through June 30, 2014, prospective rates will be increased by $.28/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by $.28/day.
3. For the rate period July 1, 2015 through June 30, 2016, prospective rates will be increased by $.02/day.
4. For the rate periods after June 30, 2016, prospective rates will not be increased by a DME rate add-on.

31-008.06C2 ICF/DDs with 4-15 beds:

31-008.06C2a Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a fiscal year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions.

31-008.06C2b Final Rate: The Department pays each ICF/DD with 4-15 beds a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and
5. The ICF/DD Revenue Tax Cost Component. This component is not retroactively settled (see 31-008.06C8b).

The final rate is the sum of the above five components.

31-008.06C3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry and housekeeping, property and plant, and administrative services.

31-008.06C3a ICF/MRs with 16 or more beds: Both the resident care services and the support services portions of the personnel operating cost component of the prospective rate are the lower of:

1. The allowable personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by the Inflation Factor computed under provisions of 471 NAC 31-008.06C7, or
2. The facility's Personnel Operating Cost Model, adjusted by the Inflation Factor computed under provisions of 471 NAC 31-008.06C7.

31-008.06C3b Personnel Operating Cost Model: The personnel operating cost model cost per day for each facility is determined based on each facility's average actual occupancy per day limited to an average occupancy of not less than 15 residents per day, level of care resident mix, staffing standards, and reasonable wage rates as adjusted for reasonable fringe benefits.

31-008.06C3b(1) Staffing Standards: The following staffing standards, in combination with the standard wage rates as described in 471 NAC 31-008.06C3b(2), are used to determine each facility's efficient and adequate personnel cost. The 19 staff categories and respective standards are used to determine total efficient and adequate personnel cost and are not intended to be required staffing levels for each staff category. All standard hours per resident day are paid hours and, therefore, include vacation, sick leave, and holiday time.

The staff categories and standards are as follows:

	Hours per Resident Day
Staff Categories	All
Direct Care Staff -Aides, attendants, houseparents, counselors, house managers	6.5160
Direct Care Admin. -QMRPs, residential service/ program coordinators, direct care supervisors	0.9105

Hours per Resident Day

Active Treatment Services	All
-Physical therapists & assistants	0.0620
-Occupational therapists & assistants	0.0830
-Psychologists	0.0940
-Speech therapists & audiologists	0.0700
-Social workers	0.1390
-Recreation therapists	0.1460
-Other professional & technical staff	0.4330
Medical Services	
-Health services supervisor	--see description following-
-Registered nurses	--see description following-
-LPN or vocational nurses	0.1975
Dietary	
-Dietitian, nutritionists	0.0230
-Food service staff	0.5540
Laundry & Housekeeping	
-Laundry & housekeeping personnel	0.3940
Property & Plant	
-Maintenance personnel	0.3000
Administration	
-Administrator	--see description following--
-Assistant administrators	--see description following--
-Other support personnel	--see description following--

The standard for the Health Services Supervisor position is one full-time equivalent employee, which will result in a varying number of standard hours per resident day depending upon the number of resident days. The standard hours per resident day for registered nurses are 0.1885 reduced by the Health Services Supervisor hours per resident day. However, these standard hours may not reduce the facility below one full-time equivalent for the combined Health Services Supervisor and R.N. positions.

The standard for the Administrator position is one full-time equivalent employee. The standard for assistant administrators is based on facility size and is as follows:

Number of Residents	Number of Assistant Administrators
1 to 100	None
101 to 200	1
201 to 300	2
301 to 400	3
401 to 500	4
501 and over	5

For other support personnel, the standard hours per resident day are 0.608, reduced by the assistant administrators' hours per resident day.

31-008.06C3b(2) Standard Wage Rates: Wage rates for each personnel category will be determined annually based on the actual average wage rates of the Beatrice State Developmental Center for the current cost report period.

31-008.06C3c ICF/MRs with 4-15 beds: Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06C4 ICF/MR Non-Personnel Operating Cost Component: This component includes all costs
other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers.

31-008.06C4a ICF/MRs with 16 beds or more: The nonpersonnel operating cost component of the prospective rate is the lower of:

1. The allowable non-personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC 31-008.06C7;
2. 110 percent of the mean allowable non-personnel operating cost per day for all ICF/MR facilities, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC 31-008.06C7; or

3. 30 percent of the weighted mean for all ICF/DD facilities Personnel Operating Cost Model adjusted by the Inflation Factor computed under 471 NAC 31-008.06C7. The mean will be weighted by the Nebraska Medicaid ICF/DD days.

31-008.06C4b ICF/DDs with 4-15 beds: The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/DD provider's most recent cost report period.

31-008.06C5 ICF/DD Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, gross revenue tax, and other fixed costs. The fixed cost component is the allowable fixed cost per day as computed for the facility's most recent cost report period.

31-008.06C6 ICF/DD Ancillary Cost Component: The ancillary cost component of the rate is the allowable ancillary cost per day as computed for the facility's most recent report period.

31-008.06C7 ICF/DD Inflation Factor: The Inflation Factor is determined from spending projections computed using:

1. Audited cost and census data following the initial desk audits;
2. Budget directives from the Nebraska Legislature; and
3. Effective for the rate period beginning July 1, 2015 and for subsequent rate periods, proceeds from the ICF/DD Reimbursement Protection Fund as specified in Nebraska Revised Statute 68-1804(4)(e).

31-008.06C8 ICF/DD Revenue Tax Cost Component:

31-008.06C8a ICF/DDs with 16 or more beds: Under the ICF/DD Reimbursement Protection Act, the ICF/DD revenue tax per diem is computed as the prior report period net revenue multiplied by the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003). The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06C8b ICF/DDs with 4-15 beds: Under the ICF/DD Reimbursement Protection Act, the ICF/DD revenue tax per diem is computed as the prior report period net revenue multiplied by the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003.) The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06C9 ICF/MR Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increases(s).

31-008.06D Rates for State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF/MR): The Department pays State-operated ICF/MR providers an amount equivalent to the reasonable and adequate costs incurred during each Reporting Period. An interim per diem rate is paid during the calendar year Rate Period, based on financial and statistical data as submitted by the ICF/MR for the most recent Reporting Period. The interim rate is settled retroactively to the facility's actual costs, which determine the Final Rate. The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and
5. The ICF/MR Revenue Tax Cost Component.

The rate is the sum of the above five components. Rates cannot exceed the amount that can reasonably be estimated to have been paid under Medicare payment principles.

31-008.06D1 Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a calendar year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions.

31-008.06D2 Final Rate: The Department pays each ICF/MR a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

31-008.06D3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry, and housekeeping, property and plant, and administrative services. Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D4 Non-Personnel Operating Cost Component: This component includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers. The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/DD provider's most recent cost report period.

31-008.06D5 Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs. The Fixed Cost Component of the Final Rate is the allowable fixed cost per day as computed for the ICF/DD provider's most recent cost report period.

31-008.06D6 ICF/DD Revenue Tax Cost Component: Under the ICF/DD Reimbursement Protection Act, the ICF/DD revenue tax per diem is computed as the prior report period net revenue multiplied by the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003.) The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06E 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 agreement. The rate will not exceed the average per diem being paid to Nebraska non-State-operated facilities for services in a similar care classification. The payment is not subject to any type of adjustment.

31-008.06F Initial Rates for New Providers:

31-008.06F1 Initial Rates for New Providers of ICF/MRs with 16 beds or more: Providers entering the NMAP as a result of a change of ownership will receive rates as follows. The rate in effect at the time of the change in ownership will be paid to the new provider for the remainder of the rate period. For the next rate period, the cost reports for all owners during the report period will be combined. The combined report will be the complete cost report for that facility and will be used for rate determinations and limitation determinations.

Providers entering the NMAP as a result of new construction, a facility re-opening, or a certification change from Nursing Facility to ICF/MR will receive a prospective rate equal to the average prospective rate of all Nebraska non-State-operated facilities of the same care classification. The rate will change at the beginning of a new rate period. The rate will be based on the care class average until the provider's first rate period following participation in the program for one full report period.

31-008.06F2 Initial Rates for New Providers of ICF/MRs with 4-15 beds: New providers entering the NMAP will be required to submit a proposed budget. The initial rate will be negotiated between the provider and the Department.

New providers as a result of a change in ownership will be required to submit a proposed budget. The initial rate will be negotiated between the provider and the Department.

31-008.07 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreement (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 ICF/MR 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 ICF/MR determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 31-008.05J and 31-008.05K.

31-008.07A Definitions: The following definitions apply to depreciation:

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

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

31-008.07B 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.

31-008.07B1 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 its facility, but the threshold amount must be at least $100 and no greater than $5,000.

31-008.07B2 Acquisitions: If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical 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 a historical 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.

31-008.07B3 Acquisitions Under $100: Acquisitions after July 1, 2004 with a per unit cost of less than $100 cannot be depreciated. Costs of these items are to be included in the applicable operating cost category on the Cost Report in the current period.

Examples:

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

31-008.07B4 Integrated System Purchases: When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.

31-008.07B5 Multiple Items: 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 should describe how the provider elects to treat these items. For example, depending on the provider's capitalization policy, stand-alone office furniture (e.g., chairs, freestanding desks) with per item costs that are under the capitalization threshold may be expensed as numerous single items, or the total cost of all items may be capitalized as an aggregate single purchase.

31-008.07B6 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.

31-008.07B7 Betterments and Improvements: Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (e.g., asbestos removal) of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

For the costs of betterments and improvements, the guidelines in 471 NAC 31-008.07B1 through 31-008.07B6 must be followed. For example, if the cost of a betterment or improvement to an asset is equal to or exceeds the capitalization threshold and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, or the safety of the asset is increased significantly, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement.

31-008.07B8 The following examples show the cost report treatment of various purchases under two different capitalization policies:

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

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

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

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

31-008.07C Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines; 008.05J and 31-008.05K);

3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 31-008.05J and K)
4. Based on the fair market value at the time of donation in case of donated assets. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

31-008.07D Purchase of an Existing Facility: Unless there is a comprehensive appraisal by a Member of the Appraisal Institute (MAI), the Department uses the following guidelines to determine a reasonable allocation of the allowable basis to furniture and equipment for which "component" depreciation may be claimed.

Classification	Variable for Under 40 Beds	Basic Cost Bases For 40 to 75 Beds	Variable for Over 75 Beds
Moveable furniture	$1,000 per bed	$1,000 per bed	$1,000 per bed
Dietary equipment	2 1/2% decrease to "Basic" for each bed	$25,000	1% increase to "Basic" for each bed
Laundry equipment	"	$20,000	"
Heating equipment	"	$10,000	"
Air Cond. equipment	"	$10,000	"

31-008.07E Recapture of Depreciation: Depreciation in 471 NAC 31-008.07E refers to real property only. An ICF/MR which is sold for a profit and has received NMAP payments for depreciation must refund to the Department the lower of:

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

Depreciation Paid by State

X (Sales Price – Book Value)

Accumulated Depreciation

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

Examples:

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

Example A

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

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

Example B

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

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

31-008.07F Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

31-008.07G 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.

31-008.08 Reporting Requirements and Record Retention: Providers must submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes.

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

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

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

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

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

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

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

Facilities that provide any services other than certified ICF/MR services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any 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.

31-008.08A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Health and Human Services Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the ICF/MR 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 from the Department; or mail copies). The total fee, based on current Department policy (http://www2.dhhs.ne.gov/policies/PublicRecords.pdf), must be paid in advance. The ICF/MR will receive a copy of a request to inspect its cost report.

31-008.08B Descriptions of Form FA-66, "Long Term Care Cost Report": All providers participating in Medicaid must complete Form FA-66, consisting of Schedules "General Data," A (Parts 1 and 2), B (Parts 1, 2, 3, and 4), B-1, B-2, B-3, B-4, B-5, C, D, (Parts 1, 2, and 3), D-1, E (Parts 1 and 2), E-1, F (Parts 1 and 2) and "Certification by Officer, Owner, or Administrator." (See 471-000-41 and 471-000-42 for an example of all schedules.) For FA-66 must be completed in accordance with regulations found at 471 NAC 12-012. Form FA-66 contains the following schedules, as described:

1. General Data: This schedule provides general information concerning the provider and its financial records.
2. Schedule A, Occupancy Data: This schedule summarizes the licensed capacity and inpatient days for all levels of care.
   Part 1 identifies the certified days available, and Part 2 identifies the inpatient census data of the facility. This data is used in determining the divisor in computing the facility's per diem rate.
3. Schedule B, Revenue and Costs: This schedule reports the revenues and costs incurred by the provider. The schedule begins with the facility's trial balance, and identifies revenue offsets, adjustments, and/or allocations necessary to arrive at the Medicaid reimbursable costs.
   Part 1 identifies all revenues from patient services and any necessary offsets to costs from these revenues. Part 2 identifies other revenues realized by the facility and any necessary offsets to costs from these revenues. Part 3 identifies the facility's costs, summarizes the revenue offsets, summarizes the cost adjustments, and reports any necessary allocation of reimbursable costs. Part 4 summarizes the revenue and costs reported in parts 1, 2, and 3, and reports net income and identifies provision for income tax.

4. Schedule B-1, General Cost Allocation and Adjustment: This schedule is used when payroll costs and fringe benefits are not specifically identified by cost category on the facility's books. If the trial balance has these accounts identified to the appropriate category, this schedule is not used.
5. Schedule B-2, Transactions with Related Organizations – Report and Adjustments: This schedule identifies facility transactions that are expenditures for services and supplies furnished to the provider by organizations related to the provider by common ownership or control. Interest on loans, depreciation on fixed assets, and leases, with related organizations are reported on other schedules and are not reported on Schedule B-2.
6. Schedule B-3, Compensation of Owners, Directors and Other Related Parties – Report and Adjustment: This schedule identifies salaries/ wages/compensations paid or payable for managerial, administrative, professional, or other services, including amounts paid or payable which are for the personal benefit of the individual or are assets or services of the facility, and removes/reduces such amounts to amounts allowable for reimbursement. All such compensations must be reported even though removal/adjustment is not required.
7. Schedule B-4, Other Cost Adjustments: This schedule identifies all adjustments necessary to adjust costs to the proper category, or to adjust costs to amounts allowable for reimbursement which are not adjusted on other schedules of the report or which are not handled through allocations.
8. Schedule B-5, Statistical Data for Allocations: This schedule identifies the allocation basis used to allocate allowable costs between levels of care and the unallowable costs when direct cost accounting is not used or is impractical to use.
9. Schedule C, Comparative Balance Sheet: This schedule identifies the facility's balance sheet accounts for the previous year end and the current period. Multifacility operations which maintain balance sheet accounts on a consolidated basis may make a statement to that effect on Schedule C; however, the long-term assets and liabilities sections must be completed for the reporting facility.
10. Schedule D, Depreciation Cost: This schedule identifies summary information on the fixed assets, necessary adjustments to depreciation, and allowable depreciation. Depreciation expense allowed under the NMAP may differ from that allowed for IRS purposes. Limitations may be imposed, and only the straight-line method may be used.
    Part 1 identifies data for all fixed assets included on the facility's trial balance and any adjustments necessary to remove or adjust the assets for computation of reimbursable depreciation. Part 2 identifies all current report period fixed asset additions by line item. Part 3 identifies all current period fixed asset deletions by line item.
11. Schedule D-1, Depreciation Schedule Adjustments: This schedule identifies all adjustments needed to adjust the fixed asset value to amounts for reimbursement purposes.
12. Schedule E, Interest Cost: This schedule identifies loans, adjustments to loan balances, allowable interest expense and the interest expense limitation.
    Part 1 reports data for each loan on which interest is included on the trial balance, and any adjustments necessary to remove or adjust loans for reimbursement purposes. Part 2 computes the interest limitation adjustment necessary to limit loans to 80% of the cost of assets.

13. Schedule E-1, Loan Schedule Adjustments: This schedule identifies each adjustment needed to adjust the provider's trial balance loans to amounts used for reimbursement.
14. Schedule F, Leases: This schedule identifies items which are on long-term lease, and adjusts to actual costs of ownership when necessary.
    Part 1 reports data for each lease, including any necessary adjustment data.
    Part 2 reports the actual costs of the owner.
15. Certification of Officer, Owner, or Administrator; and Preparer Acknowledgement: This schedule attests to the accuracy of the cost report information provided to the Department; the provider is responsible for ensuring the accuracy even if the report is prepared by a third party. The statement must be signed by the owner, an officer, or the administrator of the facility, and must be acknowledged by the preparer as necessary.

31-008.09 Audits: The Department will perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Payment rates are determined after the initial desk audit is completed.

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

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

The Department may not initiate an audit:

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

This does not preclude the Department from reopening an audit in accordance with 471 NAC 31-008.13 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 31-008.13 #2 or when grounds exist to suspect that fraud or abuse has occurred.

31-008.10 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. 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. If an audit is completed during the applicable rate period, the Department will adjust the 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 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.

31-008.11 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.

31-008.12 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Department 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 and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the 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.

31-008.13 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

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

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

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

31-008.14 Sanctions: Failure to comply with any repayment provisions will result in immediate suspension of payments as outlined in 471 NAC 2-002, except that the Department is not required to give 30 days notice.

31-008.15 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under 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.

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.

31-008.16 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 ICF/DD providers are eligible to participate in an additional distribution. For FY2011-12, FY2012-13, and FY2013-14, on the second Wednesday of May, the Department will determine the amount available in the 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, will be distributed to non-state-operated ICF/DD providers by the end of May of each year based on the following methodology:

1. On the second Wednesday of May each year, the number of Medicaid resident days paid for the period from the preceding July through March will be determined for each provider; and
2. Each provider's percentage of the total will then be determined and multiplied by the amount remaining in the Fund, not to exceed a total of $600,000, in order to determine the payment for each provider.