CHAPTER 1-000 ADMINISTRATION

1-001 Introduction: This title addresses services provided under the Nebraska Medical Assistance Program (also known as Nebraska Medicaid).

1-001.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) was established under Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Neb.Rev.Stat. §68-1018. NMAP is administered statewide by the Nebraska Department of Health and Human Services Finance and Support (HHS Finance and Support or the Department).

1-001.02 Purpose: The Nebraska Medical Assistance Program was established to provide medical and other health-related services to aged, blind, or disabled persons; dependent children; and any persons otherwise eligible who do not have sufficient income and resources to meet their medical needs.

1-001.03 Title XIX Plan: The State Plan for Title XIX of the Social Security Act - Medical Assistance Program is a comprehensive written commitment of the state to administer the Nebraska Medical Assistance Program in accordance with federal requirements. The Title XIX Plan is approved by the Federal Department of Health and Human Services. The approved plan is a basis for determining federal financial participation in the state program. The rules and regulations of NMAP implement the provisions of the Title XIX Plan.

1-002 Nebraska Medicaid-Coverable Services: The Nebraska Medical Assistance Program covers the following types of service, when medically necessary and appropriate, under the program guidelines and limitations for each service:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Rural health clinic services;
4. Federally qualified health center services;
5. Laboratory and x-ray services;
6. Nurse practitioner services;
7. Nursing facility (NF) services;
8. Home health services;
9. Early and periodic screening, diagnosis, and treatment (HEALTH CHECK);
10. Family planning services;
11. Physician services and medical and surgical services of a dentist;
12. Nurse midwife services;
13. Prescribed drugs;
14. Services in intermediate care facilities for the mentally retarded (ICF/MR);
15. Inpatient psychiatric services for individuals under age 21;
16. Inpatient psychiatric services for individuals age 65 and older in an institution for mental diseases;
17. Personal assistance services;
18. Clinic services;
19. Psychologist services;
20. Dental services and dentures;
21. Physical therapy services;
22. Speech pathology and audiology services;
23. Medical supplies and equipment;
24. Prosthetic and orthotic devices;
25. Optometric services;
26. Eyeglasses;
27. Private duty nursing services;
28. Podiatry services;
29. Chiropractic services;
30. Case management services;
31. Medical transportation, including ambulance services;
32. Occupational therapy services;
33. Emergency hospital services;
34. Screening services (mammograms); and
35. Home and community-based waiver services (see Title 480 NAC).

(Certain services covered under the home and community-based waivers may not meet the general definition of "medical necessity" and are covered under the NMAP.)

1-002.01 Nebraska Medicaid Managed Care Program: Certain Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program also known as the Nebraska Health Connection (NHC). The Department developed NHC to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State. Enrollment in NHC is mandatory for certain clients in designated geographic areas of the state. The client's participation in NHC will be indicated on the client's NHC ID Document. NHC clients will receive a Nebraska Medicaid Identification Card. Participation in NHC can be verified by accessing the Department Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580) (see 471-000-124); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or using the standard electronic Health Care Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transaction Instructions at 471-000-50).

NHC utilizes two models of managed care plans to provide the basic benefits (medical/surgical) package; these models are health maintenance organizations (HMO's) and primary care case management (PCCM) networks. NHC also provides a mental health and substance abuse services (MH/SA) benefits package that is available statewide to all clients who are required to participate in NHC. See 471-000-122 for a list of NHC's plans.
Services included in the benefits package that are provided to a client who is participating in NHC must be coordinated with the plan. The requirements for provision of services in the NHC benefits package are included in the appropriate Chapters of this Title. Services that are not included in the benefits package will be subject to all requirements of this Title.

For clients enrolled in an NHC plan for the basic benefits package, copayments are required only for prescription drugs. Clients enrolled only in the NHC mental health/substance abuse plan are subject to copayments required under 471 NAC 3-008 ff.
1-002.02 Limitations and Requirements for Certain Services

1-002.02A Medical Necessity: NMAP applies the following definition of medical necessity:

Health care services and supplies which are medically appropriate and -

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

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered.

Approval by the federal Food and Drug Administration (FDA) or similar approval does not guarantee coverage by NMAP. Licensure/certification of a particular provider type does not guarantee NMAP coverage.

1-002.02B Place of Service: Covered services must be provided at the least expensive appropriate place of service. Payment for services provided at alternate places of service may be reduced to the amount payable at the least expensive appropriate place of service, or denied, as determined by the appropriate staff of the Medicaid Division.

1-002.02C Experimental or Investigational Services: NMAP does not cover medical services which are considered investigational and/or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, NMAP prohibits payment for these services.

Within this part, medical services include, but are not limited to, medical, surgical, diagnostic, mental health, substance abuse, or other health care technologies, supplies, treatments, procedures, drugs, therapies, and devices.
1-002.02C1 Related Services: NMAP does not pay for associated or adjunctive services that are directly related to non-covered experimental/investigational services (for example, laboratory services, radiological services, other diagnostic or treatment services, practitioner services, hospital services, etc.).

NMAP may cover complications of non-covered services once the non-covered service is completed (see 471 NAC 1-002.02L).

1-002.02C2 Requests for NMAP Coverage: Requests for NMAP coverage for new services or those which may be considered experimental or investigational must be submitted before providing the services, or in the case of true medical emergencies, before submitting a claim. Requests for NMAP determinations for such coverage must be submitted in writing to the NMAP Medical Director at the following address by mail or fax method:

Medical Director  
Nebraska Department of Health and Human Services Finance and Support  
Medicaid Division  
P.O. Box 95026  
Lincoln, NE  68509-5026  
Fax Phone Number: (402) 471-9092

The request for coverage must include sufficient information to document that the new service is not considered investigational/experimental for Medicaid payment purposes. Reliable evidence must be submitted identifying the status with regard to the criteria below, cost-benefit data, short and long term outcome data, patient selection criteria that is both disease/condition specific and age specific, information outlining under what circumstances the service is considered the accepted standard of care, and any other information that would be helpful to the Department in deciding coverage issues. Additional information may be requested by the Medical Director.

Services are deemed investigational/experimental by the Medical Director, who may convene ad hoc advisory groups of experts to review requests for coverage. A service is deemed investigational/experimental if it meets any one of the following criteria:

1. There is no Food and Drug Administration (FDA) or other governmental/regulatory approval given, when appropriate, for general marketing to the public for the proposed use;
2. Reliable evidence does not permit a conclusion based on consensus that the service is a generally accepted standard of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease/proposed use and age group. Also, facility specific data, including short and long term outcomes, must be submitted to the Department;

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

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

1-002.02C3 Definition of Clinical Trials: For services not subject to FDA approval, the following definitions apply:

- **Phase I**: Initial introduction of an investigational service into humans.

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

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

1-002.02D Cosmetic and Reconstructive Surgery: NMAP limits reimbursement for cosmetic and reconstructive surgical procedures and medical services that are performed when medically necessary for the purpose of correcting the following conditions:

1. Limitations in movement of a body part caused by trauma or congenital conditions;
2. Painful scars/disfiguring scars in areas that are visible;
3. Congenital birth anomalies;
4. Post-mastectomy breast reconstruction; and
5. Other procedures determined to be restorative or necessary to correct a medical condition.
1-002.02D1 Exceptions: To determine the medical necessity of the condition, the Department requires prior authorization for cosmetic and reconstructive surgical procedures, except for the following conditions:

1. Cleft lip and cleft palate;
2. Post-mastectomy breast reconstruction;
3. Congenital hemangioma’s of the face; and
4. Nevus (mole) removals.

1-002.02D2 Cosmetic and Reconstructive Prior Authorization Procedures: In addition to the prior authorization requirements under 471 NAC 18-004.01, the surgeon who will be performing the cosmetic or reconstructive (C/R) surgery shall submit a request to the Medical Director. This request must include the following:

1. An overview of the medical condition and medical history of any conditions caused or aggravated by the condition;
2. Photographs of the involved area(s) when appropriate to the request;
3. A description of the procedure being requested including any plan to perform the procedure when it requires a staged process; and
4. When appropriate, additional information regarding the medical history may be submitted by the client's primary care physician.

Prior authorization request for cosmetic and reconstructive surgery must be submitted 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) or in writing by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services Finance and Support Medicaid Division
P.O. Box 95026
Lincoln, NE  68509-5026

Fax Telephone Number:  (402) 471-9092

1-002.02E Preventive Health Care:  To ensure early detection and treatment, to maintain good health, and to ensure normal development, NMAP provides the HEALTH CHECK program to clients age 20 and younger. HEALTH CHECK is a program of early and periodic screening, diagnosis, and treatment (EPSDT) designed to combine the health services of screening, diagnosis, and treatment with outreach, supportive services, and follow-up to promote and provide preventive health care. See 471 NAC 33-000.

Other preventive health care services covered by NMAP are listed in the individual provider chapters.
1-002.02F  Family Planning Services:  NMAP covers family planning services, including consultation and procedures, when requested by the client. Family planning services and information must be provided to clients without regard to age, sex, or marital status, and must include medical, social, and educational services. The client must be allowed to exercise freedom of choice in choosing a method of family planning. Family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician or registered nurse.

Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

1-002.02G  Services Provided Outside Nebraska:  Payment may be approved for services provided outside Nebraska in the following situations:

1. When an emergency arises from accident or sudden illness while a client is visiting in another state and the client's health would be endangered if medical care is postponed until s/he returned to Nebraska;
2. When a client customarily obtains a medically necessary service in another state because the service is more accessible;
3. When the client requires a medically necessary service that is not available in Nebraska; and
4. When the client requires a medically necessary nursing facility (see 471 NAC 12-014.04) or ICF/MR (see 471 NAC 31-003.05) service not available in Nebraska.

1-002.02G1  Prior Authorization Requirements:  Prior authorization is required for services provided outside Nebraska when -

1. The service is not available in Nebraska (see 471 NAC 1-002.02G, items 3 and 4); or
2. The service requires prior authorization under the individual chapters of this Title.

1-002.02G2  Prior Authorization Procedures for Out-of-State Services:  The referring physician shall submit a request to the Department 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) or by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services Finance and Support Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026

Fax telephone number:  (402) 471-9092

For prior authorization procedure for nursing facility services, see 471 NAC 12-014.04.  For prior authorization procedures for ICF/MR services, see 471 NAC 31-000.
The request must include the following information or explanation as appropriate to the case:

1. A summary of the client's physician's evaluation of the client and the determination that the service is not available in Nebraska, or if available, the service is not adequate to meet the client's needs;
2. The name, address, and telephone number of the out-of-state provider;
3. An indication of whether the out-of-state provider is enrolled or is willing to enroll as a Nebraska Medicaid provider and accept the Medicaid allowable payment as payment in full for the services;
4. A description of the client's condition. The physician must certify, based on a thorough evaluation, that the services being requested are medically necessary and not experimental or investigational;
5. Identification of the physician who will be assuming follow-up care when the client returns to Nebraska;
6. Any plan for follow-up and return visits, including a timeline for the visits (for example, annually, every six months, as needed), and an explanation of the medically necessity for the return visits;
7. If the client is requesting assistance with transportation, the type of transportation appropriate for the client's condition, and when ambulance, air ambulance, or commercial air transportation is being requested, the request must provide an explanation of medical necessity; and
8. The client’s name, address, and Medicaid recipient identification number, or date of birth.

1-002.02H  Sales Tax: The State of Nebraska is tax-exempt; therefore, providers shall not charge sales tax on claims to the Department or Medicaid. Sales tax may be an appropriate inclusion on cost reports.

1-002.02J  Services Not Directly Provided For Treatment or Diagnosis: Medicaid does not cover services provided to a client that are not directly related to diagnosis or treatment of the client's condition (for example, blood drawn from a client to perform chromosome studies because a relative has had problem pregnancies, paternity testing, research studies, etc.). Exception: For transplant-donor-related services, see 471 NAC 10-005.20 and 18-004.40.

1-002.02J1  Autopsies: Medicaid does not pay for autopsies.

1-002.02K (Reserved)
1-002.02L Services Required to Treat Complications or Conditions Resulting from Non-Covered Services: Medicaid may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

Medical inpatient or outpatient hospital services are sometimes required to treat a condition that arises from services which Medicaid does not cover. Payment may be made for services furnished under these circumstances if they are reasonable and necessary and meet Medicaid requirements in 471 NAC.

Examples of services that may be covered under this policy include, but are not limited to -

1. Complications/conditions occurring following cosmetic/reconstructive surgery not previously authorized by Medicaid (for example, breast augmentation, liposuction);
2. Complications from a non-covered medical transplant or a transplant that has not been previously authorized by Medicaid;
3. Complications/conditions occurring following an abortion not previously authorized by Medicaid; or
4. Complications/conditions occurring following ear piercing.

If the services in question are determined to be part of a previous non-covered service, i.e., an extension or a periodic segment of a non-covered service or follow-up care associated with it, the subsequent services will be denied. For example, when a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient’s prognosis, these visits are not covered.
1-002.02M Drug Rebates

1-002.02M1 Legal Basis: These regulations govern the Drug Rebate Program, established by Section 1927 of the Social Security Act, attached and incorporated by reference. The definitions and terms in Section 1927 of the Social Security Act apply to these regulations.

The Nebraska Medical Assistance Program, also known as Nebraska Medicaid, covers prescribed drugs only if the labeler has signed a Rebate Participation Agreement with the Secretary of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Coverage of prescribed drugs is subject to 471 NAC 16-000, Pharmacy Services.

1-002.02M2 Rebate Dispute Resolution: If, in any quarter, a manufacturer discovers a discrepancy in Medicaid utilization information that the manufacturer and the Department are unable to resolve in good faith, the manufacturer must provide written notice of the discrepancy by National Drug Code (NDC) number to the Department within 30 days after receiving the Medicaid utilization information.

If the manufacturer, in good faith, believes that the Medicaid utilization information is erroneous, the manufacturer must pay the Department that portion of the rebate amount claimed that is not disputed within 30 days after receiving the Medicaid utilization information. The balance due, if any, plus a reasonable rate of interest as set forth in Section 1903(d)(5) of the Social Security Act must be paid or credited by the manufacturer or by the Department by the due date of the next quarterly payment after resolution of the dispute.

The Department and the manufacturer must use their best efforts to resolve the discrepancy within 60 days of receipt of notification. If the Department and the manufacturer are not able to resolve a discrepancy within 60 days, CMS requires the Department to make available to the manufacturer the Department's administrative hearing process under 465 NAC 6.

The hearing decision is not binding on the Secretary of Health and Human Services, CMS, for purposes of his/her authority to implement a civil money penalty provision of the statute or the rebate agreement.

Nothing in this section precludes the right of the manufacturer to audit the Medicaid utilization information reported or required to be reported by the Department.

Adjustments to rebate payments must be made if information indicates that either Medicaid utilization information, average manufacturer price (AMP), or best price is greater or less than the amount previously specified.
1-002.02M3 Manufacturer Right to Appeal: Every manufacturer of a rebatable drug that has a signed rebate agreement has the limited right to appeal to the Director of Finance and Support for a hearing. This appeal right is limited to any discrepancies in the quarterly Medicaid utilization information only. No other matter relating to that manufacturer’s drugs may be appealed to the Director, including but not limited to the drug’s coverage status, prior authorization status, estimated acquisition cost, state maximum allowable cost, or allowable quantity. A manufacturer must request a hearing within 90 days of the date the Department gives notice to the manufacturer of the availability of the hearing process for the disputed drugs.

1-002.02M4 Filing a Request: If the manufacturer wishes to appeal an action of the Department, the manufacturer must submit a written request for a hearing to the Director of Finance and Support. The manufacturer must identify the basis of the appeal in the request.

1-002.02M5 Scheduling a Hearing: When the Director receives a request for hearing, the request is acknowledged by a letter which states the time and date of the hearing.

1-002.02M6 Hearings: Hearings are scheduled and conducted according to 465 NAC 6-000, Practice and Procedure for Hearings in Contested Cases Before the Department.

1-002.02M7 Supplemental Drug Rebates: In addition to the requirements for drug rebates as described and defined in 471 NAC 1-002.02M Drug Rebates, the NMAP may negotiate and contract for supplemental rebates with labelers of prescribed drugs. The negotiations and contracts may be between the labeler and the Department or an entity under contract with the Department to negotiate these supplemental rebates, including a single or multi-state drug purchasing pool. Any entity under contract with the Department shall be fee based, and there will be no financial incentives or bonuses based on inclusion or exclusion of medications from the Preferred Drug List.

Only those drugs meeting the requirements under 471 NAC 1-002.01 and which are otherwise eligible for coverage by NMAP are eligible for coverage.

Supplemental drug rebate agreements between the Department and/or the entity under contract to negotiate these agreements will be required as described under the provisions of 471 NAC 16-004.03 Preferred Drug List and Pharmaceutical and Therapeutics Committee.
1-002.02N Requirements for Written Prescriptions: The Nebraska Medical Assistance Program will not pay for written prescriptions for prescribed drugs unless executed on a tamper-resistant pad as required by federal law. This includes written prescriptions:

1. For otherwise covered prescription-only and over-the-counter drugs.
2. When Medicaid is the primary or secondary payer.
3. For drugs provided in Nursing Facilities, ICF/MR facilities, and other specified institutional and clinical settings (inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis) when the drug is separately reimbursed.

1-002.02N1 Exclusions: The following prescriptions and other items are not required to be written on tamper-resistant prescription pads:

1. Orders for drugs provided in Nursing Facilities, ICF/MR facilities, and other specified institutional and clinical settings (inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis) for which the drug is not separately reimbursed, but is reimbursed as part of a total service;
2. Refills of written prescriptions that are presented at a pharmacy before April 1, 2008;
3. Faxed prescriptions;
4. Telephoned, or otherwise orally transmitted prescriptions;
5. E-prescribing, when the prescription is transmitted electronically;
6. Prescriptions for Medicaid recipients that are paid entirely by a managed care entity; and

1-002.02N2 Effective April 1, 2008, a written Medicaid prescription must contain at least one of the following characteristics:

1. An industry-recognized feature designed to prevent unauthorized copying of a completed or blank prescription form, such as a high security watermark on the reverse side of the blank or thermochromic ink;
2. An industry-recognized feature designed to prevent erasure or modification of information written on the prescription by the prescriber, such as tamper-resistant background ink that shows erasures or attempts to change written information; or
3. An industry-recognized feature designed to prevent the use of counterfeit prescription forms, such as sequentially numbered blanks or duplicate or triplicate blanks.
Effective October 1, 2008, a written Medicaid prescription must contain all three characteristics listed in 471 NAC 1-002.02N2.

Emergency Fills: NMAP will pay for emergency fills for prescriptions written on non-tamper resistant pads only when the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant paper. The pharmacy must document the call on the face of the written prescription.
1-003 Verifying Eligibility for Medical Assistance: Providers may verify the eligibility of a client by viewing the client's current Medicaid eligibility document (see 471-000-123 for examples). Clients participating in the Nebraska Medicaid Managed Care Program will have an NHC Identification Document (see 471-000-122). Eligibility may also be verified by contacting the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124) or the client's local HHS office (see 471-000-125), or by using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transaction Instructions at 471-000-50).

When a client initially becomes eligible for medical assistance, s/he may not possess a Medicaid eligibility document until the following month. The provider shall verify the eligibility of the client(s) by contacting NMES or the local office or by using the standard electronic transaction (ASC X12N 270/271).

1-004 Federal and State Requirements: The Department is required by federal and state law to meet certain provisions in the administration of the Nebraska Medical Assistance Program.

1-004.01 Medical Assistance Advisory Committee: The Director of the Department appoints an advisory committee to advise the Director in the development of health and medical care services policies. Members of the committee include physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; members of consumers' groups, including NMAP clients; and consumer organizations, such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; the Director of Regulation and Licensure and the Director of Health and Human Services. Members are appointed on a rotating basis to provide continuity of membership.

1-004.02 Free Choice of Providers: An NMAP client may obtain covered services from any provider qualified to perform the services who has been approved to participate in NMAP. The client's freedom of choice does not prevent the Department from -

1. Determining the amount, duration, and scope of services;
2. Setting reasonable and objective standards for provider participation; and
3. Establishing the fees which are paid to providers for covered services.

Clients participating in the Nebraska Medicaid Managed Care Program are required to access services through their primary care physician.

1-004.03 Utilization Review (UR): The Department or its designee perform utilization review activities related to the kind, amount, and frequency of services billed to NMAP to ensure that funds are spent only for medically necessary and appropriate services. The Department or its designee may request information from clients' records as part of the utilization review process. In the absence of specific NMAP state UR regulations, Medicare UR regulations may apply.
1-005 Medicare Benefits (Title XVIII) Buy-In: The Department pays monthly premiums for Part B of Medicare only for clients who -

1. Are 65 years of age or older; or
2. Meet the eligibility requirements of disability in Nebraska's Assistance to the Aged, Blind, or Disabled Program.

See 471 NAC 3-004 for further information on Medicare/Medicaid crossover claims and Medicare managed care plans.
1-006 TELEHEALTH FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

1-006.01 Implementation Date: These regulations will be become operative January 1, 2017.

1-006.02 Definitions

Child: An individual under 19 years of age.

Comparable Service: A service provided face-to-face.

Distant Site: The distant site is the location of the provider of the telehealth consultation.

Originating Site: The originating site is the location of the client at the time of the telehealth consultation.

Telehealth Consultation: Any contact between a client and a health care practitioner relating to the health care diagnosis or treatment of such client through telehealth. For the purposes of telehealth, a consultation includes any service delivered through telehealth.

Telemonitoring: The remote monitoring of a client’s vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care practitioner for analysis and storage.

1-006.03 Health care practitioners providing telehealth services must follow all applicable state and federal laws and regulations governing their practice and the services they provide.

1-006.04 Originating Sites: Health care practitioners must assure that the originating sites meet the standards for telehealth. Originating sites must provide a place where the client’s right for confidential and private services is protected.

1-006.05 Informed Consent: Before an initial telehealth consultation, the health care practitioner shall provide the client the following written information which must be acknowledged by the client in writing or via email:

1. Alternative options are available, including in-person services, and these alternatives are specifically listed on the client’s informed consent statement;

2. All existing laws and protections for services received in-person also apply to telehealth, including:
   a. Confidentiality of information;
   b. Access to medical records; and
   c. Dissemination of client identifiable information;

3. Whether the telehealth consultation will be or will not be recorded;

4. The client has a right to be informed of all the parties who will be present at each telehealth consultation and has the right to exclude anyone from either the originating or the distant site;
5. For each adult client or for a client who is a child but who is not receiving telehealth behavioral health services, a safety plan must be developed, should it be needed at any time during or after the provision of telehealth. This plan shall document the actions the client and the health care practitioner will take in an emergency or urgent situation that arises during or after the telehealth consultation;

6. For each client who is a child who is receiving telehealth behavioral health services:
   a. An appropriately trained staff member or employee familiar with the child’s treatment plan or familiar with the child shall be immediately available in person to the child receiving a telehealth behavioral consultation in order to attend to any urgent situation or emergency that may occur during provision of such service. This requirement may be waived by the child’s parent or legal guardian. The medical record shall document the waiver.
   b. In cases in which there is a threat that the child may harm himself or herself or others, before an initial telehealth consultation the health practitioner shall work with the child and his or her parent or guardian to develop a safety plan. Such plan shall document actions the child, the health care practitioner, and the parent or guardian will take in the event of an emergency or urgent situation occurring during or after the telehealth consultation. Such plan may include having a staff member or employee familiar with the child’s treatment plan immediately available in person to the child if such measures are deemed necessary by the team developing the safety plan;

7. The written consent form shall become a part of the client’s medical record and a copy must be provided to the client or the client’s authorized representative;

8. If the client is a child or otherwise unable to sign the consent form, the client’s legally authorized representative shall provide the consent.

1-006.06 Telecommunications Technology: Medicaid coverage is available for telehealth and transmission costs when, the technology used meets industry standards and is HIPPA compliant.

1. The telehealth technology solution in use at both the originating and the distant site must be sufficient to allow the health care practitioner to appropriately complete the service billed to Medicaid. These same standards apply to any peripheral diagnostic scope or device used during the telehealth consultation.

2. Coverage is available for teleradiology services when the services meet the American College of Radiology standards for teleradiology.

1-006.07 Telemonitoring

1. Medicaid will reimburse for telemonitoring when all of the following requirements are met:
   a. Telemonitoring is covered only when the services are from the originating site;
   b. The client is cognitively capable to operate the equipment or has a willing and able person to assist in the transmission of electronic data;
c. The originating site has space for all program equipment and full transmission capability; and
d. The provider must maintain a client’s record containing data supporting the medical necessity of the service, all transmissions and subsequent review received from the client, and how the data transmitted from the client is being utilized in the continuous development and implementation of the client’s plan of care.

2. Telemonitoring is paid at a daily per diem rate set by Medicaid and includes the following:
   a. Health care practitioner review and interpretation of the client data;
   b. Equipment and all supplies, accessories, and services necessary for proper functioning and effective use of the equipment;
   c. Medically necessary visits to the home by a health care practitioner;
   d. Training on the use of equipment and completion of necessary records.

3. No additional or separate payment beyond the fixed payment is allowable.

1-006.08 Practitioner Consultation:

1. Reimbursement: Medicaid will reimburse a consulting health care practitioner when all of the following requirements are met:
   a. After obtaining and analyzing the transmitted information, the consulting health care practitioner reports back to the referring health care practitioner;
   b. The consulting health care practitioner must bill for services using the appropriate modifier;
   c. Payment is not made to the referring health care practitioner who sends the medical documentation.

2. Exclusions: Practitioner Consultation is not covered for behavioral health when the client has an urgent psychiatric condition requiring immediate attention by a licensed mental health practitioner.

1-006.09 Reimbursement Rate of Telehealth: Telehealth is reimbursed by Medicaid at the same rate for the service when it is delivered in person.

1-006.010 Reimbursement of Transmission Costs: Transmission cost rates are set forth in the Medicaid fee schedule and include reimbursement for all two-way, real-time, interactive communications, unless provided by an Internet service provider, between the client and the physician or health care practitioner at the distant site which comply with the federal Health Insurance Portability and Accountability Act of 1996 and rules and regulations adopted thereunder and with regulations relating to the encryption adopted by the federal Centers for Medicare and Medicaid Services and which satisfy federal requirements relating to efficiency, economy and quality of care.
1-006.11 Reimbursement of Originating Site Fee: The originating site fee is paid to the Medicaid-enrolled facility hosting the client for telehealth at a rate set forth in the Medicaid fee schedule.

1-006.12 Out-of-State Telehealth is covered if the telehealth otherwise meets the regulatory requirements for payment for services provided outside Nebraska and:
1. When the distant site is located in another state and the originating site is located in Nebraska; or
2. When the Nebraska client is located at an originating site in another state, whether or not the provider's distant site is located in or out of Nebraska.

1-006.13 Documentation: The medical record for telehealth must follow all applicable statutes and regulations on documentation. The use of telehealth technology must also be documented in the same medical record, and must include the following telehealth information:
1. Documentation of which site initiated the call;
2. Documentation of the telecommunication technology utilized (e.g. real-time two-way interactive audio-visual transmission via a T1 Line); and
3. The time the service began and ended.
CHAPTER 2-000 PROVIDER PARTICIPATION

2-001 Provider Eligibility

2-001.01 Provider Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved Service Provider Agreement with the Department.

2-001.02 Eligibility: To be eligible to participate in the Nebraska Medical Assistance Program (NMAP), the provider shall meet the general standards for all providers in Chapters 1-000, 2-000, and 3-000 of this title, if appropriate, and the standards for participation for that provider type. The standards for participation are listed in each provider chapter of this title; in Title 480 NAC for home and community-based waiver services; and in Title 482 for managed care services. The Department shall not pay a provider who is required to be licensed and/or certified but who is not licensed and/or certified at the time of service.

2-001.02A Denial or Termination of Enrollment:

2-001.02A1 The Department in its discretion may deny or terminate a provider’s enrollment for good cause, which includes but is not limited to the following:

1. The provider does not meet the applicable provider standards for participation in NMAP as listed in Titles 404, 471, 480, and 482 or
2. The provider is the respondent of a protection order; or
3. The provider or its owner(s); managing employee(s); affiliates; or household member(s) [if services are provided in the provider’s home] committed a crime:  
   a. Against a child or vulnerable adult;  
   b. Involving the illegal use, possession, or distributions of a controlled substance; or  
   c. That, if repeated, could injure or harm the Medicaid program or a Medicaid client.

The Department deems a crime to have been committed when a conviction, admission, or substantial evidence of commission exists. In exercising its discretion, the Department considers the severity of the crime(s), the applicability of the crime(s) to the service(s) of the provider, and the amount of time that has passed since the commission of the crime(s).

2-001.02A2 The Department must deny or terminate the enrollment of a provider where any person with a 5% or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person’s involvement with a Medicare, Medicaid or Title XXI program within the last ten years, unless the Department determines that denial or termination of enrollment is not in the best interest of the Medicaid program.
2-001.02A The Department must deny or terminate the enrollment of a provider that has been excluded or terminated from participating in Medicare or Medicaid or CHIP in any State.

2-001.02B Provider Screening: The Department will screen all providers as provided in 42 C.F.R. Part 455, Subpart E and will deny or terminate the enrollment of any provider that fails to meet all applicable requirements.

2-001.02C Ordering or Referring Providers: Ordering and referring physicians or other professionals must be enrolled providers and must include their National Provider Identifier (NPI) on any claims for items or services ordered or referred.

2-001.02D Revalidation: The Department must revalidate the enrollment of all providers at least every five years.

2-001.02E Application Fee: At initial enrollment, re-enrollment, reactivation, and revalidation providers must submit to the Department an application fee before the Department can execute a Service Provider Agreement. Exempt from this application fee requirement are the following:

1. individual physicians and nonphysician practitioners;
2. providers enrolled in or that have paid an application fee to Medicare or another State’s Medicaid or CHIP program; and
3. providers or categories of providers that have received an application fee waiver from CMS.

2-001.02F Site Visits: A provider must permit CMS and the Department to conduct unannounced onsite inspections of any and all provider locations. The Department may terminate the enrollment of a provider who fails to permit a site visit.

2-001.02G Temporary Moratoria:

1. The Department must impose temporary moratoria on the enrollment of new providers or provider types that pose an increased risk to the Medicaid program as identified by the Secretary of the United States Department of Health and Human Services unless the Department determines that a temporary moratorium would adversely affect access to medical assistance.
2. The Department may impose temporary moratoria or place numerical caps or other limits on the enrollment of new providers that it and/or the Secretary of the United States Department of Health and Human Services have identified as having significant potential for fraud, waste, or abuse unless the Department determines that such action would adversely affect access to medical assistance.
3. A moratorium imposed under this section lasts for an initial period of six months and if necessary may be extended in six-month increments by the Department.
2-001.03 Service Provider Agreements: Each provider must have an approved Service Provider Agreement with the Department. By signing the Service Provider Agreement, a provider agrees to:

1. Fully meet standards established by the federal Department of Health and Human Services, and any applicable state and federal laws governing the provision of their services;
2. Provide services according to the regulations and procedures of the Department for NMAP;
3. Provide services in compliance with Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973;
4. Accept as payment in full the amount paid in accordance with the rates established by the Department after all other sources (including third party resources, Medicare, or excess income) have been exhausted. Exception: If a client resides in a nursing facility, a payment to the facility for the client to occupy a single room is not considered income in the client's budget if Medicaid is or will be paying any part of the nursing facility care;
5. Submit to the Department charges which do not exceed the provider's charges to the general public for equivalent goods or services;
6. Submit claims which are true, accurate, and complete;
7. Maintain records for all services provided for which a claim has been made, and furnish, on request, the records to the Department, the federal Department of Health and Human Services, and the federal or state fraud and abuse units and document services rendered in an institutional setting in the client's institutional chart before billing the Department;
8. Submit claims electronically, if applicable, under proper signature of the provider or the provider's authorized representative, and follow all other applicable billing requirements;
9. Maintain computer software used in the submission of claims and furnish, on request, the documentation to the Department, the federal Department of Health and Human Services and the federal or state fraud and abuse units;
10. Follow the submittal procedures, record layout requirements, service verification requirements, and provider and/or authorized representative certification requirements for the electronic submission of claims; and
11. Refrain from establishing a policy to automatically waive copayment or deductibles established by the Department.

The Department may terminate the Service Provider Agreement of a provider who fails to meet these requirements.

A Service Provider Agreement is not an employment agreement and enrollment as an NMAP provider does not constitute employment by or with the Department.

2-001.03A Signature Date of Provider Agreement: A provider agreement must be signed and on file with the Department before payment for services is made. Payment may be made for covered services provided before the signature date of the agreement if the agreement is signed and on file with the Department before payment and the provider met all eligibility requirements at the time the service was provided.
2-001.03B Required Forms: Providers must complete, sign, and submit to the Department the following forms as appropriate:

1. Form MC-19, "Medical Assistance Provider Agreement"
2. Form MLTC-62, "Nebraska Ownership/Controlling Interest and Convictions Disclosure";
3. All applicable addendum forms;
4. Form "United States Citizenship Attestation form"; and
5. Form MS-84 "State of Nebraska ACH/EFT Enrollment Form".

Certain providers of home and community-based services must also complete provider agreement forms as indicated in Title 480. Certain providers of medical transportation services must also complete the provider agreement form as indicated in Titles 473 and 474.

The Department may require a provider to periodically complete a new Service Provider Agreement to update information or eligibility, and may terminate the enrollment of a provider that fails to comply with this requirement.

2-001.03C Approval and Enrollment: The Department will review each submitted Service Provider Agreement and upon approval and enrollment will assign to the provider a Medicaid provider number to use to bill Medicaid.

2-001.04 Standards for Participation: Providers shall meet the following minimum standards:

1. Accept the philosophy of service provision which includes acceptance of, respect for, and a positive attitude toward Medicaid clients and the philosophy of client empowerment;
2. Meet any applicable licensure or certification requirements and maintain current licensure or certification;
3. Obtain adequate information on the medical and personal needs of each client, if applicable;
4. Not discriminate against any client, employee, or applicant for employment because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90, and 41 CFR Part 60;
5. Agree to a law enforcement check and Adult Protective Services and Child Protective Services Central Registry checks;
6. Operate a drug-free workplace;
7. Attend training on the NMAP as deemed necessary by the Department;
8. Provide services within the scope of practice under applicable licensure or certification requirements; and
9. Agree to maintain up-to-date and accurate provider agreement information by submitting any changes to the Department.

Employees of providers are subject to the same standards.

2-001.05 Employees as Providers: No employee of the Department and its subdivisions, except clinical consultants, may serve as providers of medical services under the Nebraska Medical Assistance Program or as paid consultants to providers under the Nebraska Medical Assistance Program without the express written approval of the Director.
2-001.06 Principles of Providing Medical Assistance: Medical care and services are provided through NMAP to maintain good physical and mental health, to prevent physical disease and disability, to mitigate disease, and to rehabilitate the individual. The amount and type of service required is defined for each case through utilization review. The provider shall limit services to essential health care. The plan for providing services within program guidelines through NMAP is based on the following principles:

1. All plans for medical care must provide for essential health services and for integration of treatment with social planning to reduce economic dependency;
2. Medical care and services must be coordinated with health services available through existing public and private sources;
3. Medical care and services must be provided as economically as is consistent with accepted standards of medical care and fair compensation to providers;
4. Medical care and services must be within the licensure of the provider giving the care or service; and
5. The client must be allowed, within these limitations, to exercise free choice in the selection of a qualified provider.

2-001.07 Provider Handbooks: The Department issues provider handbooks for specific provider types addressed in this Title. Each provider handbook contains -

1. Chapters 1-000, 2-000, and 3-000 of Title 471;
2. The appropriate provider chapter; and
3. Instructions for forms and electronic transactions.

While the handbooks contain policy related to specific provider groups, they may not contain all rules and regulations of NMAP for all possible circumstances. In these cases, regulations contained in the Nebraska Department of Health and Human Services Finance and Support Manual will prevail. The individual provider is responsible for ensuring that s/he has an up-to-date provider handbook, that s/he has all applicable rules and regulations, and that employees, consultants, and contractors are informed about the regulations of this program.

2-001.08 Provider Bulletins: The Medicaid Division may issue provider bulletins to inform providers of regulation interpretations.

2-001.09 Electronic Information Exchange: Any entity that exchanges standard electronic transactions with the Department must have an approved trading partner agreement with the Department.
2-002  Administrative Sanctions

2-002.01  Purpose: This section -

1. Establishes the basis on which certain claims for NMAP services or merchandise will be determined to be false, fraudulent, abusive, or in violation of NMAP policies, procedures, and regulations;
2. Lists the sanctions which may be imposed; and
3. Describes the method of imposing the sanctions.

The Program Integrity Unit in the Medicaid Division has responsibility for these functions.

2-002.02  Definitions: The following definitions apply within this section:

**Abuse**: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Nebraska Medical Assistance Program (NMAP) or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. This may include under-utilization, lack of treatment, or lack of appropriate referrals. Abuse also includes client practices that result in unnecessary cost to NMAP.

**Affiliates**: Persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

**Billing**: Presenting, or causing to be presented, a claim for payment to the Department, its agents, or assignees.

**Billing Agent**: An entity that submits or facilitates the submission of claims for payment to the Department.

**Claim**: A request for payment for services rendered or supplied by a provider to a client.

**Clearinghouse**: An entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or data content for a receiving entity.

**Closed-End Provider Agreement**: An agreement that is for a specific period of time that must be renewed to allow the provider to continue to participate in NMAP.

**Excluded Person or Entity**: Any individual or entity that has been formally denied enrollment or continued participation in NMAP or that is on or eligible to be on State or Federal exclusion list(s).

**Exclusion**: Prohibition from participating in NMAP or associating with an enrolled provider.
Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Fraud includes, but is not limited to, the willful false statement or representation, or impersonation or other device, made by a client or applicant, provider, Departmental employee, or any other person, for the purpose of obtaining or attempting to obtain, or aiding or abetting any person to obtain -

1. An assistance certificate of award to which s/he is not entitled;
2. Any commodity, food stuff, food coupon, or payment to which the individual is not entitled or a larger amount of payment than that to which the individual is entitled;
3. Any payment made on behalf of a client of medical assistance or social services;
4. Any other benefit administered by the State of Nebraska, its agents or assignees; or
5. Assistance in violation of any statutory provision relating to programs administered by the Nebraska Department of Health and Human Services Finance and Support.

Initial Enrollment: A provider’s first time enrolling with Nebraska Medicaid

NHC: The Nebraska Health Connection (Medicaid managed care).

NMMCP: The Nebraska Medicaid Managed Care Program.

Open-Ended Provider Agreement: An agreement that has no specific termination dates and continues in force as long as it is agreeable to both parties.

Other Individuals or Entities Associated with the Enrolled Provider: Ancillary healthcare professionals or staff who do not see Medicaid patients but are associated with a provider. This includes but is not limited to an owner, managing employee, office staff, and other indirect care staff.

Overutilization: A documented pattern of ordering or performing and billing tests, examinations, medical visits, and/or surgeries, drugs and merchandise for which there is no demonstrable need, when the determination of demonstrable need is made by the Medicaid Medical Director or consultants.

Participation: Participation in NMAP includes providing, referring, furnishing, ordering, or prescribing services to a Medicaid client or causing services to be provided, referred, furnished, ordered, or prescribed for a Medicaid client.

Payment: Reimbursement or compensation by the Department, its agents, or assignees, e.g., managed care plans.

Person: Any individual, company, firm, association, corporation, or other legal entity.
Provider: Any person which furnishes Medicaid goods or services under an approved provider agreement with the Department.

Proper Patient Waiver: An agreement by which the client or client's legal representative agrees to release his/her medical records to state or federal authorities accomplished by the client signing Form DA-100, "Application for Assistance."

Reactivation: Enrollment of a provider whose previous Service Provider Agreement was terminated by the Department.

Re-enrollment: Enrollment of a provider whose previous Service Provider Agreement expired or was voluntarily closed by the provider.

Revalidation: Process by which the Department confirms a provider’s enrollment-related information is valid, updated, and accurate.

Suspension of Payments: Withholding of payments due a provider until the resolution of the matter in dispute between the provider and the Department.

Termination from Participation: An Exclusion from participation in NMAP, which includes the following types:
   1. Permanent;
   2. Time-limited, which is an exclusion for a specified period of time;
   3. Technical, which is based on a provider’s failure to meet a standard or requirement and remains in effect until the Department determines the provider meets the standard or requirement; and
   4. Emergency, which is an immediate exclusion based on the Department’s determination that client health and safety may be at risk.


Trading Partner: A health care plan, provider or clearinghouse that transmits any health information in electronic form.

Underutilization: Lack of treatment/referrals when there is a demonstrable need, when the determination of demonstrable need is made by the Medicaid Medical Director or consultants.

Usual and Customary Charge: Charge to the general public.

Withholding of Payments: A reduction or adjustment of the amounts paid to the provider on pending and subsequently submitted claims to offset overpayments previously made to the provider.

2-002.03 Reasons for Sanctions: The grounds for the Department to impose sanctions include, but are not limited to, the following:

1. Presenting, or causing to be presented, any false or fraudulent claim for goods or services or merchandise for payment;
2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater payment than that to which the provider is legally entitled;
3. Billing in excess of the usual and customary charges;
4. Altering medical records to obtain a higher classification of the client than is truly warranted;
5. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization/approval requirements, or obtaining payments prior to the effective date;
6. Failing to disclose or make available to the Department, or its authorized representatives, records of services provided to NMAP clients and records of payments by the Department, its agents and others made for those services, when requested;
7. Failing to provide and maintain quality, necessary, and appropriate services within accepted medical standards as determined by a body of peers, as documented by repeat deficiencies noted by the survey and certification agency, a peer review committee, medical review teams, or independent professional review teams, or by the determination of the Medicaid Director and/or consultants, or the Department or its designee, the Department's Quality Assurance Committee, any Department Inspection of Care, or a managed care plan's quality assurance committee;
8. Breaching the terms of the Medicaid provider agreement or submitting false or fraudulent application for providing participation;
9. Violating any provision of the Nebraska laws regarding NMAP or any rule or regulation of NMAP;
10. Failing to comply with the terms of the provider certification on the Medicaid claim form;
11. Overutilizing the Medicaid program by inducing, furnishing, or otherwise causing a client to receive services or merchandise not otherwise required by the client, ordered by the attending physician, or deemed appropriate by utilization review committee. Note: A determination of overutilization may be based on a comparison of treatment practices of a specific provider compared to peers for similar types of clients;
12. Underutilizing the Medicaid program by not furnishing required services;
13. Presenting a claim, billing, or causing a claim to be presented for payment for services not rendered (including "no-shows");
14. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;
15. Soliciting, offering, or receiving a kickback, bribe, or rebate;
16. Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries;
17. Failing to meet standards required by state or federal law for participation (e.g., licensure and/or certification);
18. Not accepting Medicaid payment as payment in full for covered services and collecting or attempting to collect additional payment from others, the client or responsible person, or collecting a portion of the service fee from the client or the client's family, except for required co-payments;
19. Refusing to execute a new provider agreement at the Department's request, failing to update as required in 471 NAC 20-001.09C, 32-004.03A, and 35-002 or failing to update provider agreement information when changes have occurred;
20. Failing to correct deficiencies in operations or improper billing practices after receiving written notice of these deficiencies/practices from the Department or its agent (for example, HHS Regulation and Licensure for home and community-based waivers, managed care plans);
21. Being formally reprimanded or censured by an association of the provider's peers for unethical practices;
22. Being suspended or terminated from participation in another governmental medical program such as Worker's Compensation, Medically Handicapped Children's Program, Vocational Rehabilitation Services, Medicare, or Medicaid in another state or a Medicaid managed care plan; being convicted for civil or criminal violations of NMAP, or any other state's Medicaid (medical assistance) program; or having sanctions applied by the Department's agents or assignees or any other state's Medicaid program;

23. Failing to repay or make arrangements for the repayment of overpayments or otherwise erroneous payments;

24. Submitting duplicate bills, including billing NMAP twice for the same service, or billing both NMAP and another insurer or government program;

25. Billing before the goods or services are provided or dispensed prior to the date of billing (pre-billing);

26. Any action resulting in a reduction or depletion of a nursing facility or ICF/MR Medicaid client's personal allowance funds or reserve account (liquid assets) unless specifically authorized in writing by the client, or legal representative;

27. Billing for services provided by non-enrolled providers, sanctioned providers, or excluded persons;

28. Billing for services rendered by someone else as though the provider performed the services him/herself;

29. Billing for services provided by an individual who is required to be licensed or certified and who did not meet that requirement when the service was provided;

30. Billing for services provided outside the provider's scope of practice;

31. Upgrading services billed and rendered from those actually provided;

32. Upcoding services billed or billing a higher level of service than those actually provided;

33. Reporting of unallowable cost items on a provider's cost report or reporting any item which is obviously unallowable except when the unallowable entry was included in the cost report only to establish a basis for appeal;

34. Violating conditions of an exclusion;

35. Violating conditions of probationary or restricted licensure;

36. Not having the appropriate Drug Enforcement Administration (DEA) license or state drug license;

37. Loss, restriction, or lack or hospital privileges;

38. Failure or inability to provide and maintain quality, necessary and appropriate services due to physical or mental health conditions of the service provider;

39. Endangering health and safety of clients;

40. Failure to obtain or maintain required surety bond(s);

41. Failure to provide Department with documentation of authorization for third party to submit claims for the provider for payment to the Department or failing to update this information when changes have occurred; or

42. Breaching the terms of a Trading Partner Agreement to exchange information electronically.
2-002.04 Sanctions

2-002.04A The Department may impose one or more of the following sanctions against a provider:

1. Termination from participation in the Medicaid program;
2. Termination from participation in the NMMCP (NHC);
3. Suspension or withholding of payments;
4. Recoupment from future payments;
5. Transfer to a closed-end service provider agreement not to exceed 12 months, or the shortening of an already existing closed-end provider agreement; or
6. Provider education.

2-002.04B The Department may impose the sanction of exclusion upon other individuals or entities associated with an enrolled provider.
2-002.05  Imposition of a Sanction: The decision on the sanction to be imposed is at the discretion of the Director. The following factors are considered in determining the sanctions to be imposed:

1. Seriousness of the offenses;
2. Extent of violations;
3. History of prior violations;
4. Prior imposition of sanctions;
5. Prior provision of provider education;
6. Provider willingness to comply with program rules;
7. Whether a lesser sanction will be sufficient to remedy the problem; and
8. Actions taken or recommended by peer review groups and licensing boards.

The Department must notify the provider at least 30 days before the effective date of the sanction, unless extenuating circumstances exist. The Department shall give the provider an opportunity to submit additional information or to appeal the sanction. The provider must file the appeal within 30 days of the date of the notice of the sanction. When the clients’ health and safety is threatened, appropriate administrative sanctions may be taken without a full evidentiary hearing. The provider may file an appeal regarding this action; however, the sanction will remain in effect until the hearing decision is made. When a sanction is imposed, the Department shall give general notice to the public of the restriction, its basis, and its duration.

To prevent inappropriate Medicaid payments or to avoid further overpayments, the Department may sanction a provider by suspending the provider’s payments with an immediate effective date. The Department will notify the provider by letter that its payments have been suspended. The provider may file an appeal regarding this action; however, the suspension of payments will remain in effect until the hearing decision is made.

If a provider participates under one or more provider number, or changes numbers, payments can be suspended, withheld or recouped from one or all of the provider numbers.

2-002.05A  Conditions of Termination: When a provider is terminated from NMAP, NMAP may not make reimbursement for services, items, or drugs that are provided, referred, furnished, or prescribed by the terminated provider or caused to be provided, referred, furnished, ordered, or prescribed for a Medicaid client.

A Medicaid client may not be billed for any services provided, referred, furnished, ordered, or prescribed by an excluded provider.

Exception: NMAP may pay claims from a submitting provider, such as a pharmacy, until the submitting provider and the client are notified of the termination of the prescribing/attending provider. NMAP may pay claims for emergency medical services when Medicaid Division staff or consultants determine that the services were medically necessary.
2-002.05B Sanction of Affiliates: The Department may sanction all known affiliates of a provider when each decision to include an affiliate is made on a case by case basis after considering all relevant facts and circumstances. The Department may determine the affiliate's violation, failure, or inadequacy of performance when the provider's action which resulted in a sanction took place in the course of the affiliate's official duty or with the knowledge or approval of the affiliate.

2-002.05C Claims: Termination or exclusion from participation shall preclude a provider from submitting claims for payment, either personally or through any clinic, group, corporation, or other association, to the Department for any services or supplies provided under NMAP, except for those services or supplies provided before the termination or exclusion.

2-002.05D Excluded Person or Entity: No clinic, group, corporation, or other association which is a provider of services shall submit claims for payment to the Department for any services or supplies provided by a person within the organization which has been excluded from participation in NMAP except for those services or supplies provided before the termination. If these provisions are violated by a clinic, group, corporation, or other association, the Department may terminate the organization and/or any individual person within the organization responsible for the violation.

A provider shall not submit any claims to NMAP that contain the costs of services provided by excluded persons or entities.

2-002.05E Notification of Other Agencies: When a provider has been sanctioned, the Department shall notify, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

2-002.05F Notification of Local HHS Offices: When a provider's participation in NMAP has been terminated, the Department will notify the local HHS offices of the termination.

2-002.05G Provider Education: A provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include:

1. Telephone and written instructions;
2. Provider manuals and workshops;
3. Instruction in claim form completion;
4. Instruction in the use and format of provider manuals;
5. Instruction in the use of procedure codes;
6. Key provisions of the Medicaid program;
7. Instructions on reimbursement rates; and
8. Instructions on how to inquire about coding or billing problems.
2-002.05H Denial of Enrollment: At the discretion of the Department, providers who have previously been terminated may or may not be reactivated as providers of Title XIX (Medicaid) services.

2-002.05J Reactivation: At the end of the termination period, the provider may request in writing that the Department reactivate the Service Provider Agreement. The Medicaid Division may approve or deny reactivation of the provider agreement. The provider may be reactivated conditionally with a closed-end provider agreement or other restrictions or requirements.

2-002.06 Audits: All services for which claims for payment are submitted to the Department are subject to audit. During a review audit, the provider must furnish to the Department, or its authorized representative, pertinent information regarding claims for payment. If an audit reveals that incorrect payments were made or that the provider's records do not support payments that have been made, the provider shall make restitution.

2-002.06A Sampling and Extrapolation: The Department's procedure for auditing providers may involve the use of sampling and extrapolation. Under this procedure, the Department selects a statistically valid sample of the services for which the provider received payment for the audit period in question and audits the provider's records for these services. All incorrect payments determined by an audit of the services in the sample are totaled and extrapolated to the entire universe of services for which the provider has been paid during the audit period. The provider shall pay to the Department the entire extrapolated amount of incorrect payments calculated under this procedure after notice and opportunity for hearing under 471 NAC 2-002.05 and 2-003.

2-002.06B Hearings: The Department must allow the provider an opportunity to rebut the Department's audit findings. If the findings are based on sampling and extrapolation, the provider may present an independent 100% audit of his/her Medicaid payments during the audit period in lieu of accepting the Department's sampling and extrapolation. Any audit of this type must demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with the Department's regulations. The provider must be prepared to submit supporting documentation to demonstrate this compliance.
2-003 Appeal Rights: Any adverse action under this Title may be appealed to the Medicaid Director by the person or entity against whom the action was taken.

2-003.01 Hearing Request Procedure: The person or entity appealing an adverse action must submit a written hearing request to the Department.

2-003.01A Deadlines:
1. Administrative sanctions must be appealed within 30 days of the date of the action.
2. Refund requests must be appealed within 30 days of the date of the action indicated either on the Refund Request Report or the notice of action letter.
3. All other actions must be appealed within 90 days of the date of the action.

2-003.01B Appealing before effective date: A person or entity may appeal a termination or exclusion before the effective date of the proposed termination or exclusion. A termination or exclusion appealed before its effective date will not take effect until the appeal has been decided, unless the termination or exclusion is being imposed pursuant to 42 C.F.R. 455.416(c) or has an immediate effective date because of a threat to client health and safety.

2-003.02 Hearings: Appeal and hearing procedures are governed by Title 465, Chapter 6.

2-003.03 (RESERVED)
2-003.04 (RESERVED)
2-003.05 (RESERVED)
2-003.06 Long Term Care Facilities Appeals Process

2-003.06A Appeal of Denial, Termination, or Non-Renewal of Certification: Any nursing facility or intermediate care facility for the intellectually disabled (ICF/ID) whose Medicaid certification has been denied, terminated, or not renewed may appeal to the Nebraska Department of Health and Human Services Regulation and Licensure (HHS Regulation and Licensure), which will conduct the hearings under Rule 56 of the Rules of Practice and Procedure adopted by HHS Regulation and Licensure.

2-003.06B Skilled Nursing Facility (SNF) Medicare/Medicaid Participation: If an SNF is participating, or seeking to participate, in both Medicare and Medicaid, and if the basis for the Department's denial, termination, or non-renewal of participation in Medicaid is also a basis for denial, termination, or non-renewal in Medicare, the facility is entitled to the review procedures specified for Medicare facilities under 42 Code of Federal Regulations (CFR) Part 405 Subpart O. The final decision entered under the Medicare review procedures will be binding for purposes of Medicaid NF participation. If the SNF is also certified for Medicaid NF participation, a separate appeal must be made to HHS Regulation and Licensure.

2-003.06C Appeal of Denial, Termination, or Non-Renewal of Medicaid Provider Agreements: Any NF or ICF/ID whose Medicaid provider agreement has been denied, terminated, or not renewed may appeal to the Director for a hearing under this section.
2-004 Client Lock-In: The Department investigates clients who through utilization review, provider referral, or local office referral are identified as misutilizing medical assistance services. If the investigation establishes that the client has abused or overutilized services provided through the Nebraska Medical Assistance Program, the client may be locked-in. The Department's Utilization Review Committee makes the decision to lock-in a client.

2-004.01 Definition of Lock-In: Lock-in is a method used by the Department to ensure appropriate utilization of medical services by a client who has been determined to be abusing or overutilizing services provided by NMAP without infringing on the client's free choice of a provider.

2-004.02 Lock-In Categories: The client may be locked-in to one of the following categories:

Note: Payment for medical emergencies and referrals to other physicians may be covered under 471 NAC 2-004.04.

2-004.02A Category 1: One pharmacy. The client chooses one pharmacy. The Department will approve payment for prescriptions only from that pharmacy. Other covered services are not restricted.

2-004.02B Category 2: One primary physician and one pharmacy. The client chooses one primary physician and one pharmacy.

2-004.02C Category 3: One primary physician, one pharmacy, and one hospital. The client chooses one primary physician, one pharmacy, and one hospital for outpatient services. Inpatient hospital admissions are exempt.

2-004.02D Category 4: One prescribing physician and one pharmacy. The client chooses one prescribing physician and one pharmacy. Only prescriptions authorized by the prescribing physician and dispensed by the pharmacy will be approved for payment. This category allows the client to visit other physicians without restriction.

2-004.02E Category 9: All types of service. The client must choose only one provider for each type of service s/he wishes to receive.

2-004.03 Choice of Lock-In Provider(s): The client is allowed to choose the provider(s). The primary physician or the prescribing physician must be an individual, as opposed to a partnership, clinic, teaching institution, or hospital staff.

A client in the lock-in program who is enrolled in the Nebraska Health Connection is allowed to choose his/her provider. The provider chosen as the lock-in provider must be the provider who is the client's primary care physician (PCP) under NHC.

2-004.03A Change of Primary Provider: The choice of provider(s) may be changed at any time upon demonstration by the client of good cause, which is determined by the Utilization Review Committee. The client is allowed to change the provider(s) every three months without demonstration of good cause. All requests for change must be submitted to the Utilization Review Committee through the local office by submitting a revised Form MC-66, "Recipient Choice of Provider Agreement."
2-004.04 Services by Other Providers: Claims for services provided to a lock-in client by other than the chosen provider(s) will not be approved, with the following exceptions:

2-004.04A Medical Emergencies: Emergency care is defined as medically necessary services provided to an individual who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions. The provider shall document in writing any emergency situation. The documentation must be attached to any claim submitted to the Department.

2-004.04B Primary Physician Referrals: A primary physician may make a written referral of a lock-in client to another physician, dentist, osteopath, or podiatrist. Claims submitted may be approved for payment if a copy of the written referral from the primary physician is attached to the claim. Lock-in referrals may be approved for a reasonable amount of time for the condition being treated. If this time is exceeded, the Department may require a new referral letter from the primary physician.

2-004.04C Other Medical Services: Services by providers other than physicians, osteopaths, dentists, and podiatrists do not require a written referral from the primary physician.

2-004.05 Lock-In Notification: The Utilization Review Committee notifies the client, the client's local office, and Nebraska Health Connection (NHC) if the client is participating in NHC (or current enrollment broker for managed care) of the lock-in restriction through Form MC-38 at least ten days before imposing lock-in. Form MC-38:

1. Explains the lock-in restriction, stating that the restriction does not apply to emergency services furnished to the client;
2. Provides reasons for the lock-in;
3. Provides appropriate manual references;
4. Informs the client and local office of the client’s right to an appeal hearing; and
5. Explains that the client has 90 days to request a hearing in writing, and that if the client requests a hearing in writing within 10 days, the Lock-In will be delayed until a hearing decision is rendered.

2-004.05A Client Appeal Rights: The lock-in client has the right to appeal for a hearing. The client or the client’s representative has 90 days following the date of notification to request a hearing in writing. If a hearing is requested in writing within ten days following the date of notification, the lock-in restriction will be delayed until a hearing decision is rendered.
2-004.06  Lock-In Agreement: Within ten working days following the date of the lock-in notification, the local office, NHC or client shall submit Form MC-66, "Recipient Choice of Provider Agreement," (see 471-000-93) to the Utilization Review Committee. The client and witness shall sign the agreement. The agreement identifies the provider(s) chosen by the client and states that the chosen provider(s) will be the only provider(s) of service.

2-004.06A Failure to Provide Agreement: Failure by the lock-in client or the local office to provide the agreement will result in the Department designating the provider(s) for the client or restricting the eligibility of the client to "emergency services only" (see 471 NAC 2-004.07).

2-004.06B Effective Date of Lock-In Agreement: The effective date of the lock-in agreement is either: 1) The first day of the month following the month in which the client signed the agreement; or 2) The date the agreement is signed, if requested by the lock-in client, caseworker or NHC and approved by the state; or 3) Another date, if requested by the lock-in client, caseworker or NHC and approved by the state.
2-004.07 Eligibility Information: Lock-in status may be verified by accessing the Department Internet Access for Enrolled Providers (http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580) (see 471-000-124); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128), or electronically by using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

If "emergency services only" is indicated, the provider may render only emergency services. The provider shall document in writing any emergency situation and the documentation must accompany any claim submitted to the Department for payment.

2-004.07A Provider Determination of Lock-In Status: The provider shall determine the client's lock-in status by accessing the Department Internet Access for Enrolled Providers (http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or electronically by using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). NMES will allow the provider to obtain current eligibility information (including lock-in status) and is operational 24 hours per day, seven days per week. (See 471-000-124 for instructions on using NMES.)

When a client initially becomes eligible for medical assistance, s/he may not have a Medicaid Identification Card at the time of the appointment. The provider shall verify the eligibility of the client(s) by contacting one of the eligibility verification systems listed above or the local office, or by using the standard electronic transaction.

2-004.08 Pharmacy Claims: Pharmacy claims submitted for prescriptions dispensed to a lock-in client by providers other than those designated on the Nebraska Medicaid Eligibility System may not be paid except in a bona fide emergency. The pharmacy shall document in writing the emergency situation.

Due to the circumstances necessitating the lock-in, the Department will approve for payment only prescriptions authorized by the primary or prescribing physician. Prescriptions by other practitioners (dentist, podiatrist, referral physician, etc.) will not be approved unless the primary or prescribing physician authorized them.

2-004.09 Client's Lock-In File: The Utilization Review Committee maintains a complete case file for each lock-in client at the Central Office. The client or the client's representative may request in writing a copy of all information contained within this file.
2-004.10 Review of Lock-In Status: The Utilization Review Committee, or its designee, will review the client’s lock-in status every 24 months on the continued appropriateness of the lock-in.

At least 10 days before lock-in is extended, the Utilization Review Committee notifies the client, the client’s local office, and Nebraska Health Connection if the client is participating in NHC (or current enrollment broker for managed care) of the review of the client’s lock-in status. The notice:

1. Explains the outcome(s) of the review, which may include continuing lock-in status for another 24 months, changing lock-in category (see 471 NAC 2-004.02), or removing lock-in status;
2. Provides reasons for the outcome(s), according to the criteria listed in 471 NAC 2-004.10A;
3. Provides appropriate manual references;
4. Informs the client, local office and NHC of the client’s right to an appeal hearing; and
5. Explains that the client has 90 days to request a hearing in writing, and that if the client requests a hearing in writing within 10 days, no change will be made until a hearing decision is rendered.

2-004.10A: The client’s lock-in status may be continued, changed or removed following the review of lock-in status based on the following reasons:

1. Use of controlled substances, carisoprodol, tramadol or other drug(s) with abuse potential; or
2. Early prescription refills, as defined in the drug claim processing system; or
3. Use of drugs which are known to interact with other drugs, diseases, conditions or foods; or
4. Use of medications indicating multiple medical conditions with complex medication regimens; or
5. Patient safety, including use of medication(s) with narrow therapeutic index; or
6. Abuse or overuse of medical services; or
7. History of drug abuse, medication-seeking behavior, non-compliance, emergency room overuse or abuse; or
8. Coverage by Medicaid of services from non-lock-in providers in non-emergency situations; or
9. Report(s) of obtaining Medicaid coverable drugs by paying cash; or
10. Other similar reasons.
In addition to the biennial review, the client or the client's primary physician may request a review of the client's lock-in status. Any request for review must contain a statement from the client's primary physician indicating that the client's medical history and/or treatment plan has been completely reviewed and stating the change in lock-in status being recommended, along with reasons supporting this recommendation. The Utilization Review Committee will notify the lock-in client, local office and NHC, if the client is participating in NHC, of its decision within ten days from the date the request is received. Requests for review of lock-in status will be limited to once per year, unless the client can demonstrate good cause. Good cause will be determined by the Utilization Review Committee.

2-005 Advance Directives: An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (statutory or as recognized by the courts of the state) that relates to the provision of medical care if the individual becomes incapacitated.

All Medicaid-participating hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations, and health insuring organizations shall comply with this section. They shall -

1. Maintain written policies, procedures, and materials concerning advance directives;
2. Provide written information (see 471-000-304) to all adult (as defined by state law) individuals receiving medical care by or through the provider or organization concerning their rights under state law to -
   a. Make decisions concerning their medical care;
   b. Accept or refuse medical or surgical treatment; and
   c. Formulate advance directives, such as living wills or durable power of attorney for health care;
3. Provide written information to all adult individuals on the provider's policies concerning implementation of these rights;
4. Document in the individual's medical record whether the individual has executed an advance directive;
5. Not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive;
6. Ensure compliance with requirements of state law (whether statutory or as recognized by the courts of the state) concerning advance directives; and
7. Provide for educating staff and the community on advance directives.
2-005.01 When Providers Give Information Concerning Advance Directives: Providers shall give information concerning advance directives to each adult patient as follows:

1. A hospital shall give information at the time of the individual's admission as an inpatient;
2. A nursing facility shall give information at the time of the individual's admission as a resident;
3. A provider of home health care or personal care services shall give information to the individual in advance of the individual's coming under the care of the provider;
4. A hospice program shall give information at the time of initial receipt of hospice care by the individual; and
5. An HMO/HIO shall give information at the time the individual enrolls with the organization, i.e., when the HMO enrolls or re-enrolls the individual. If an HMO has more than one medical record for its enrollees, it must document all medical records.

2-005.02 Information Concerning Advance Directives at the Time an Incapacitated Individual Is Admitted: An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether s/he has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it shall also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once s/he is no longer incapacitated.

2-005.03 Previously Executed Advance Directives: When the patient or a relative, surrogate, or other concerned or related individual presents the facility with a copy of the individual's advance directive, the facility shall comply with the advance directive to the extent allowed under state law. This does not preclude a facility from objecting as a matter of conscience, if it is permitted to do so under state law.

Absent contrary state law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether s/he has executed an advance directive, the facility shall note that the individual was not able to receive information and was unable to communicate whether an advance directive existed.
2-006 Disclosure of Information by Providers: Under 42 CFR 455, Subpart B, the Department requires providers to disclose the following information:

1. Ownership and control;
2. Business transactions; and
3. The providers' owners and other persons convicted of crimes against Medicare, Medicaid, or Title XX (Social Services Block Grant) programs.

2-006.01 Ownership and Control: For each managing employee, person or entity with an ownership or control interest in the provider, and subcontractor of which the provider owns at least five percent, a provider must disclose the following:

1. The name, address (including, as applicable, the primary business address, every business location, and P.O. Box address), date of birth or incorporation, and Tax Identification Number or social security number as applicable;
2. Whether any is related to another as spouse, parent, child, or sibling; and
3. The name of any other disclosing entity in which a person named in 471 NAC 2-006.01(1) has an ownership or controlling interest.

For purposes of this section, "person with an ownership or control interest" means a person who:

1. (a) Has directly or indirectly an ownership interest of five per centum or more in the entity;
   (b) Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds five per centum of the total property and assets of the entity; or
2. Is an officer or director of the entity, if the entity is organized as a corporation; or
3. Is a partner in the entity, if the entity is organized as a partnership.

The term "managing employee" means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

Any provider that is subject to periodic survey and certification of its compliance with Medicaid standards must supply this information to the Department at the time it is surveyed. Any provider that is not subject to periodic survey and certification must supply the information before entering into an agreement with the Department.
The Department must not approve a Service Provider Agreement, and must terminate an existing agreement, if the provider fails to disclose ownership or control information. The Department must not pay a provider who fails to disclose ownership or control information.

A provider shall notify the Department of any changes or updates to the information supplied under 471 NAC 2-006.01 not later than 35 days after such changes or updates take effect.

2-006.02 Business Transactions: Under 42 CFR 455.105(b) when requested, a provider must disclose within 35 days of the date on the request information:

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending with the date of the request; and
2. Any significant business transaction between the provider and any wholly-owned supplier, or between the provider and any sub-contractor, during the five-year period ending on the date of the request.

The Department must not pay providers who fail to comply with a request for this information, or pay for services provided during the period beginning on the day following the date the information was due to the Department and ending on the day before the date the Department received the information.

2-006.03 Persons Convicted of Crimes: Before the Department enters into or renews a Service Provider Agreement, or upon request by the Department, the provider must disclose to the Department the identity of any person who -

1. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
2. Has been convicted of a criminal offense related to that person's involvement in any problem under Medicare, Medicaid, CHIP (Title XXI), or the Social Services Block Grant (Title XX) programs since the inception of those programs.

The Department may refuse to enter into or renew a provider agreement if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP (Title XXI), or the Social Services Block Grant (Title XX). The Department may deny or terminate enrollment if it determines that the provider did not fully and accurately disclose this information.
CHAPTER 3-000 PAYMENT FOR MEDICAID SERVICES

3-001 Definitions:

**Claim** means a request for payment for services rendered or supplied by a provider to a client.

**Clearinghouse** means an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction and receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard or nonstandard data content for the receiving entity.

**HCPCS** means the Healthcare Common Procedure Coding System. This contains the national codes adopted by the federal Secretary of Health and Human Services and includes American Medical Association’s Current Procedural Terminology (CPT) Level I procedure codes and Level 2 procedure codes.

**Indian** means an individual, defined at 25 U.S.C. sections 1603(c), 1603(f), and 1679(b), or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization – I/T/U) or through referral under Contract Health Services.

**Indian Health Care Provider** means a health care program, including contract health services, operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined 25 U.S.C. 1603.

**Standard Transaction** means an electronic transaction that complies with the applicable standard adopted under federal law.

**Transaction** means the exchange of information between two parties to carry out financial or administrative activities related to health care.

**Trading Partner Agreement (TPA)** means an agreement related to the electronic exchange of information.

**Warrant** means a paper check or electronic funds transfer.

3-002 Approval and Payment

**3-002.01 Approval**: Payment for medical care and services through Medicaid funds must be approved by the Department. Claims will be approved for payment when all of the following conditions are met:

1. A provider agreement is on file with the Department, as well as the certification and transmittal from the state licensing agency or the Centers for Medicare and Medicaid Services (CMS) Regional Office when required;
2. The client was eligible for Medicaid when the service was provided, or the service was provided during the period of retroactive eligibility;
3. No more than 6 months have elapsed from the date of service when the claim is received by the Department (see 471 NAC 3-002.01A for exceptions);
4. The medical care and services are within the guidelines of Medicaid;
5. The client's case record must contain information to meet state requirements; and
6. A trading partner agreement has been approved, if required, for clearinghouses, billing agents, and providers submitting claims using electronic transactions.

3-002.01A Exceptions: Payment may be made by the Department for claims received more than 6 months after the date of service if the circumstances which delayed the submittal were beyond the provider's control. Some circumstances that are considered by the Department to be beyond the provider's control include, but are not limited to -

1. Provider's eligibility;
2. Client's retroactive eligibility;
3. Client's failure to submit appropriate information;
4. Unusual Central Office delay; or
5. Third party casualty situations (see 471 NAC 3-004.06C).

The Department shall determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

Payment may be made by the Department for claims that are received within one year after the date of service for Medicaid-approved special education services provided by school districts, as authorized by Neb. Rev. Stat. § 43-2511.

3-002.01B Timely Payment of Claims: The Department shall pay claims within 12 months of the date of receipt of the claim. This time limitation does not apply to -

1. Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system;
2. Claims which have been filed in a timely manner for payment by Medicare, for which the Department may pay a Medicaid claim relating to the same services. Claims for the Medicaid portion must be submitted to the Department within six months from the date of the Medicare remittance advice;
3. Claims from providers under investigation for alleged fraud or abuse;
4. Payments made -
   a. In accordance with a court order;
   b. To carry out hearing decisions or agency corrective actions taken to resolve a dispute;
   c. To extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it; or
5. Third party casualty situations as specified in 471 NAC 3-004.06C.

3-002.01C Denial: The Department shall not pay claims received more than two years after the date of service, except under the circumstances specified in 471 NAC 3-002.01B or 3-004.06B.
3-002.01D Provider’s Failure to Cooperate in Securing Third Party Payment: The Department may deny payment of a provider’s claims if the provider fails to apply third party payments to medical bills, to file necessary claims, or to cooperate in matters necessary to secure payment by insurance or other liable third parties.

3-002.02 Payment

3-002.02A Upper Limits: The Department has established upper limits for payment as described in each provider chapter.

3-002.02B Coverage Exception: Certain medical services, while being medically necessary, may exceed the NMAP coverage guidelines which have been established by the Department. Under these circumstances, the determination of medical necessity for payment purposes is based upon the professional judgment of the Department's consultants and other appropriate staff.

3-002.02C Payment in Full: Providers participating in NMAP shall agree to accept as payment in full the amount paid according to the Department’s payment methodologies after all other sources have been exhausted.

Exception: If a client resides in a nursing facility, a payment to the facility for the client to occupy a single room is not considered income in the client’s budget if Medicaid is or will be paying any part of the nursing facility care.

3-002.02D Charges to the General Public: Providers shall not exceed their charges to the general public when billing NMAP. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to Medicaid clients who would otherwise qualify for the discount.

3-002.02E Method of Payment: Effective January 1, 2009, payment for all approved medical services within the scope of NMAP will be made by electronic funds transfer (EFT) to the provider who supplied the services.

3-002.02F Billed Charges: If the provider’s billed charges are less than the Department’s allowable payment, the Department pays the provider’s billed charges.

Exception: Inpatient hospital services are paid on a diagnosis-related group (DRG) or per diem basis, regardless of billed charges.

3-002.03 Post-Payment Review: Payment for a service does not indicate compliance with NMAP policy. Monitoring may be accomplished by post-payment review to verify that NMAP policy has been followed. A refund will be requested if post-payment review finds that NMAP payment has been made for claims/services not in compliance with NMAP policy. During a post-payment review, claims submitted for payment may be subjected to further review or not processed pending the outcome of the review.
3-002.04 Payment for Medical Expenses: Payment may not be made from NMAP funds for medical expenses which have been paid from county funds or other public or private sources.

3-002.05 Excess Income/Share of Cost: Individuals who are otherwise eligible but who have excess income shall obligate the excess amount for medical care before payment for medical services can be approved through NMAP. Obligation or payment of the excess amount is documented on Form DSS-160, "Record of Health Cost-Share of Cost-Medicaid Program" (see 471-000-79). For further information, the provider may contact the client's local office.

3-002.06 Inquiry on Status of Claims: For questions regarding claim status, providers may contact Department staff as directed in the claim submission instructions in the appendix to this Title or the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277) (see standard Electronic Transaction Instructions at 471-000-50). Providers may direct questions regarding regulations to the Medicaid Division.

3-002.07 Adjustments to Payment Reductions or Disallowances: Providers are restricted to a maximum time limitation of 90 days to request an adjustment to a claim that has been paid with a portion reduced or disallowed, or a claim that has been disallowed in total, unless documentation of extenuating circumstances is submitted to the Medicaid Division. The 90-day limitation begins with the payment date of the paper remittance advice (Form MCP-248) or with the payment date of the electronic remittance advice (ASC X12N 835).

3-002.08 Refunds

3-002.08A Refunds Requested by the Department: When the Department requests a refund of all or part of a paid claim, the provider is allowed 30 days to refund the amount requested, to show that the refund has already been made, or to document why the refund request is in error or appeal. The provider's failure to respond within 30 days shall be cause for the Department to recoup from future provider payments until the situation is resolved or to sanction the provider. The refund request shall constitute notice of the sanction to recoup from future payments. For refunds due to third party resources, see 471 NAC 3-004.10.

Note: NE-POP providers may be requested to void claims through the NE-POP system instead of submitting checks.

3-002.08B Third Party Liability Refunds: Whenever third party liability payments are received after a claim has been submitted to the Department, the provider shall refund the Department within 30 days. The refund must be accompanied by a copy of the documentation, such as the explanation of benefits or electronic coordination of benefits.
3-002.08C Provider Refunds to the Department: Providers have the responsibility to review all payments to ensure that no overpayments have been received. The provider shall refund all overpayments to the Department within 30 days of identifying the overpayment.

3-002.09 Claim Reports: These claim reports are issued weekly.

3-002.09A Remittance Advice: Remittance advice for payment of approved services is issued electronically using the standard Health Care Claim Payment/Advice transaction (ASC X12N 835) or on paper with Form MCP248 Remittance Advice (see 471-000-85).

3-002.09B Refund Request: A request for refund is issued electronically or on paper with Form MCP248 Refund Request.

3-002.09C Rejected Claims, Deleted Claims, and Denied Adjustments: Rejected claims, deleted claims, and denied adjustments are reported on Form MCP524, Electronic Claims Activities Report.

3-002.10 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 to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director 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. At any time fraud or abuse is suspected.

A provider has no right to a hearing on a finding by the Director that a reopening or correction of a determination or decision is not warranted.

3-002.11 Billing the Client: Providers participating in NMAP agree to accept NMAP's payment as payment in full. The provider shall not bill the client for Medicaid coverable services if the claim is denied by the Department for lack of medical necessity or for failure to follow a procedural requirement (such as prior authorization, claim submission instructions, timely claims filing limits, etc.). The provider shall not
bill the client for services covered by NMAP. It is not a violation of NMAP's regulations for the provider to bill the client for services not covered by NMAP. It is not a violation for a provider to bill the client for services when it is determined that the client has received money from a third party resource and that money was designated to pay medical bills. See 471 NAC 3-004.10B, 3-004.05, and 3-004.05F.

If the client agrees in advance in writing to pay for the non-covered service, the provider may bill the client.

The provider has the responsibility to verify the client's eligibility for Medicaid and any limitations, such as lock-in or managed care, that apply to a specific client. It is the provider's responsibility to be aware of requirements for medical necessity, prior authorization, referral management, etc.

3-002.12 Section 1122 Sanctions: When the Department of Health and Human Services imposes a sanction under section 1122 of the Social Security Act and instructs the Department to withhold or recoup the federal share of the capital expenditure, the Department shall withhold the federal and the state share of the capital expenditure.

3-002.13 Disclosure of Information: See 465 NAC 2-005.02.

3-003 Billing Requirements

3-003.01 Claims Submission: Providers shall submit claims for payment for medical services on the appropriate Medicaid billing forms attached and incorporated into these rules or the appropriate ASC X12N health care claim format for electronic transactions.

3-003.01A Institutional Services: Claims for the following services must be submitted by using the paper Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49.):

1. Ambulatory Room & Board;
2. Assisted Living Facilities;
3. Dialysis;
4. Home Health;
5. Rural Health Clinic;
6. Hospital;
7. Hospital-Based Ambulance;
8. ICF/MR's; and
9. Nursing Facilities*.

* Form MC-4, Long Term Care Turnaround may be used for nursing facility services instead of Form CMS-1450.
3-003.01B Practitioner Services: Claims for the following services must be submitted by using the paper Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49.):

1. Ambulatory Surgical Center;  
2. Durable Medical Equipment and Supplies;  
3. Federally Qualified Health Center;  
4. Licensed Practitioner (to submit claims for Dental services, see 471 NAC 3-003.01D);  
5. Medical Transportation*;  
6. Non-Hospital-Based Ambulance;  
7. Non-Rural Health Clinic;  
8. Personal Care Aide**; and  
9. Private Duty Nursing***.

* Form MS-65 must be used for paper submission of claims for Medical Transportation Services (see 471-000-63). Form MS-66 must be used for paper submission of claims for mental health transportation services.

** Form MC-82 must be used for paper submission of claims for Personal Care Aide Services (see 471-000-60).

*** Form MC-82N must be used for paper submission of claims for Private Duty Nursing services (see 471-000-59).

*** Form MC-82-AD must be used for paper submission of claims for private duty nursing or personal care aide services provided in adult day care centers.

3-003.01C Retail Pharmacy Services: Claims must be submitted electronically via the Nebraska Point of Purchase (NE POP) system, using the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard transaction.

3-003.01D Dental Services: Claims must be submitted by paper using the American Dental Association (ADA) Dental Claim Form or the standard electronic Health Care Claim: Dental Transaction (ASC X12N 837). For instructions on claim submission, see the Claim Submission Table in the appendix at 471-000-49.

3-003.02 Claim Certification: The submission of the claim form by the provider, the provider’s authorized representative, or the provider’s billing agent on behalf of an approved provider certifies that:

1. The services were medically indicated and necessary to the health of the patient, and were personally rendered by the provider, or under the provider’s direction;  
2. The services were provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973;  
3. The amounts claimed are in compliance with the Department's policies, and no additional charge has been or will be made;  
4. The information on the claim is true, accurate, and complete;  
5. Each service is documented in the provider’s files, and documentation is available to the Department, the federal Department of HHS, and state and federal fraud and abuse units; and
6. The provider understands that payment and resolution of this claim will be made from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

3-003.02A  Paper Submission: The provider, the provider’s authorized representative, or the provider’s billing agent on behalf of an approved provider must sign the paper Medicaid billing forms that contain signature fields. Computer generated signatures are accepted and must be the signature of the service rendering provider, not the clinic or corporation. When a computer-encoded document is used as the Medicaid billing mechanism, the Department may request the provider’s source input document from the provider for input verification and signature requirements. The signature constitutes certification as required by 471 NAC 3-003.02.

3-003.02B  Electronic Submission: The submission of any electronic claim by the provider, the provider’s authorization representative, or the provider’s billing agent on behalf of an approved provider constitutes certification as required by 471 NAC 3-003.02.

3-003.03  Claims for Prolonged Care: When medical care is required for a prolonged period, such as nursing home care, extended hospital care, home health agency care, or other continuous service, the Department recommends that the provider submit claims for payment at intervals of not less than one month, so that payment may be kept current.

3-003.04  Electronic Claims and Computer-Encoded Claim Documentation: The provider shall allow the authorized representatives of the federal Department of HHS, the Department, and state and federal fraud and abuse units to review and audit the provider’s or the provider’s billing agent’s or clearinghouse’s data processing procedures and supportive software documentation involved in the production of the computer-encoded claims or electronic claims submitted to the Department. The provider has agreed to allow the Department and its authorized representatives access to its records under the provider agreement.
3-004 Third Party Resources (TPR): All third party resources available to a Medicaid client must be utilized for all or part of their medical costs before Medicaid. Third party resources (TPR) are any individual, entity, or program that is, or may be, contractually or legally liable to pay all or part of the cost of any medical services furnished to a client. Third party resources include, but are not limited to -

1. Private health insurance;
2. Casualty insurance, including medical payment provisions;
3. Employment-related group health insurance;
4. Group health plans defined under section 607(1) of ERISA;
5. Medicare Part A and/or Part B;
6. Medicare Part C (Medicare Advantage plans);
7. Medicare Part D;
8. Medical support from non-custodial parents (court or administrative ordered) (see 471 NAC 3-004.08);
9. Excess income/share of cost (see 471 NAC 3-001.05);
10. Workers’ compensation;
11. Other federal programs (unless excluded by statute, such as Indian Health Services programs and Migrant Health programs, and Title V, Maternal Child Health Program);
12. Liable third parties who are not insurance carriers;
13. Medical payments provisions of automobile and commercial insurance policies; and
14. Any other party contractually or legally liable to pay medical expenses.

The Nebraska Chronic Renal Disease Program and the Medically Handicapped Children's Program are not included as TPR. Medicaid payment is made only after all third party resources have been exhausted or met their legal contractual or legal obligations to pay. Medicaid is the payor of last resort.

3-004.01 Definitions: The Nebraska Medical Assistance Program (NMAP) uses the following definitions in relation to third party resources:

Adjudicate: To determine whether a claim or adjustment is to be paid or denied.

Balance Billing: Billing NMAP or client for remaining amount left after a provider has agreed to accept a lesser amount from the primary payor as payment in full. Balance billing is prohibited.

Casualty Insurer: An insurance policy that pays for medical care as a result of an accident, incident, injury, disability, or disease; for example, automobile insurance, homeowners insurance, commercial liability insurance, product liability insurance, workers compensation, etc.

Client Assignment of Rights: The client's action to assign to the Department his/her rights (and the rights of any other eligible individuals on whose behalf s/he has legal authority under state law to assign such rights) to medical support and to payment for medical care from any third party resource (except Part A and B of Medicare). Assignment of rights is accomplished by signing the Medicaid application.
Commercial/Cost-Share Copayment: Fixed payment amounts, as determined by the insurer (including Medicare Advantage plans), that an individual must pay to access services.

Cost Avoidance: A method of adjudicating claims as payor of last resort in order to utilize all third party resources before Medicaid payment can be made.

Denial: Non-payment of benefits by a third party resource. See 471 NAC 3-004.06D1.

Excess Income/Share of Cost: The amount of the client's income that must be obligated or paid for medical care before Medicaid payment can be made.

Health Insurer: Any group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act (ERISA) of 1974 (amended in 1993), an entity offering a service benefit plan, or a health maintenance organization (HMO).

HMO Plan: Health Maintenance Organization - A type of managed care health plan that provides health care in return for a fixed payment from a subscriber or their employer with medical care being restricted to network physicians and a referral being necessary to utilize providers outside the network.


Medical Support: The obligation of a non-custodial parent to provide health insurance and/or pay for medical care ordered by a court or administrative body established under state law.

Medicare Advantage Plan: Medicare C - Coordinated care plans that meet Medicare C (Medicare Advantage plan) standards, including health maintenance organizations (HMO) (with or without point of service options), Provider Sponsored Organizations (PSOs) and Preferred Providers Organizations (PPOs), religious fraternal benefits plans, and other coordinated care plans. Persons eligible for Medicare Part A and Part B may choose to enroll in a Medicare Advantage Plan instead of the traditional Medicare fee-for-service program. Part B only enrollees are ineligible.

Medicare/Medicaid: Persons dually eligible for Medicare and Medicaid during the same period of time.

Medicare Part A: A federal program, created by the Social Security Act of 1965, to provide coverage of hospital, skilled nursing and certain other services for Medicare beneficiaries.

Medicare Part B: A federal program, created by the Social Security Act of 1965, to provide coverage of practitioner, durable medical equipment, supplies and certain other services for Medicare beneficiaries.

Co-insurance: A dollar amount, usually expressed as a percentage, for a covered service that is not paid by the primary insurer, that is the financial responsibility of the client or other payer on behalf of the client. (For example, for Medicare Part B covered services, Medicare pays 80% of the Medicare allowable and the remaining 20% is the co-insurance amount).
Deductible: A dollar amount, other than a premium, that a client, or other payer on behalf of the client, must pay before any covered service is paid for by the insurer. (For example, the standard Medicare Part D deductible for calendar year 2006 is $250).

Coverage Gap: for Medicare Part D, the cost of Part D drugs for which there is no coverage, also known as the “doughnut hole”. (For calendar year 2006, for beneficiaries that do not qualify for the low income subsidy, the coverage gap is $2,250 to $5,100 or $2,850).

Premium: The cost of purchasing insurance, Medicare or other health insurance coverage, which may be a monthly or annual dollar amount. (For example, the Medicare Part B premium for calendar year 2005 is $78.20 per month).

Medicare Part D: A federal program, also known as the Medicare prescription drug benefit, that was created by the Medicare Modernization Act of 2003 (P.L. 108-173). This voluntary program provides coverage of certain drugs, classes of drugs or therapeutic categories of drugs and certain medical supplies or equipment for all Medicare beneficiaries, including those beneficiaries that are also eligible for Medicaid (dual-eligibles). Clients who are dual eligibles are automatically enrolled in Part D.

Medicare Part D Plan: An entity, approved by the Centers for Medicare and Medicaid Services, to provide coverage of Medicare Part D drugs and certain medical supplies related to the administration of insulin for Medicare beneficiaries under the Medicare Modernization Act of 2003 (P.L. 108-173).

Medicare Part D Drug: Any drug, class of drugs or therapeutic category of drugs that is not a Medicare Part D Excluded drug (see definition of Medicare Part D Excluded drug below), regardless of formulary, prior approval or tiering status by the Part D Plan.

Medicare Part D Excluded Drug: Any drug, class of drugs or therapeutic category of drugs that is specifically excluded from coverage under the Medicare Modernization Act of 2003 (P.L. 108-173) and amendments to that act, and/or as defined by federal regulations implementing the Medicare Modernization Act (for example, cough and cold preparations).

Medicare Part D Covered Supplies or Equipment: Insulin syringes, needles, alcohol swabs, gauze and other products related to the administration of insulin that are covered by Medicare Part D Plans.

Non-Custodial Parent: Parent who does not reside with a child but has a legal responsibility to provide court or administrative ordered medical support for the child.

Pay and Chase: A recovery method in which Medicaid pays the total amount allowed under NMAP and then seeks to recover from liable third party resources.
Private Insurer: This includes -

1. Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-related and indemnity contracts);
2. Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis and treatment of an injury, disease, or disability; and
3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments for services, including self-insured and self-funded plans (under section 607(1) of ERISA).

PPO Plan: Preferred Provider Organization - Fee for service plan with an incentive to use network providers to provide care for the plan's subscribers. Patients may see physicians outside the network but at reduced payment rate. A copayment may be required on certain services.

PSO Plan: Provider Sponsored Organization - Public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial portion of health care items and services directly through providers or affiliated groups of providers. Affiliated providers share, directly or indirectly, substantial financial risk, and have at least a majority financial interest in the PSO.

Remittance Advice: The third party plan's statement of payment for services. When billing Medicaid, this statement may be provided as a paper or electronic remittance advice, and must include the following information: the insurance company name, patient name, dates of service, charges, and amount paid. If charges were denied by insurance, the portion of the remittance advice showing the denial reason must be included.

Subrogation: Right of the state to stand in place of the client in collection of third party resources.

3-004.02 Availability of Third Party Resource Information: The Coordination of Benefits/Third Party Liability (COB/TPL) Unit of the Department of Health and Human Services Finance and Support maintains all known current health insurance, casualty insurance, and/or Medicare coverage on the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124). Providers may also obtain this information using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). If the provider becomes aware of any additional third party resources, the provider shall contact the COB/TPL Unit and report the new sources.
3-004.02A Request for Release of Patient Account Information:  To alert the Department to potential TPR, the provider shall notify the COB/TPL Unit if a provider receives a request for an itemized bill or a request for the balance of a bill from the client, an attorney, an insurance company, or employer. This does not include routine billing information requests to process insurance or Medicare. The provider may release the information in accordance with the provider's standard office practice.

3-004.03 Payor of Last Resort: Medicaid clients who have third party resources must exhaust these resources before Medicaid considers payment for any services. Medicaid shall not pay for medical services as a primary payor if a third party resource is contractually or legally obligated to pay for the service.

Providers shall bill all third party resources and/or the client (when there is an excess income/share of cost obligation) for services provided to the client, except for waiver claims (see 471 NAC 3-004.03A). Providers shall submit all charges and Medicare covered services provided to Medicare/Medicaid clients to Medicare plus any Medicare supplement plans for resolution prior to billing Medicaid. Medicaid is the payor of last resort.

3-004.03A Waiver Claims: Certain services, defined as "waiver claims," are an exception to the requirement of 471 NAC 3-004.03. Providers may submit these claims to Medicaid before filing for TPR; NMAP pays these claims and COB staff initiate recovery activities for any TPR. This does not prohibit the provider from billing the TPR before billing Medicaid. In these situations, the provider does not bill Medicaid until the claim is resolved.

Waiver claims, for health insurance purposes, are claims for which the Department has applied and received a "cost avoidance" waiver from CMS or claims that are mandated to have cost avoidance waived under 42 CFR 433.139 (preventive pediatrics, prenatal services, medical support from "uncooperative" non-custodial parents).

3-004.03B Services Not Covered by Medicare: NMAP may cover services within the scope of NMAP that are not covered by Medicare. NMAP shall not cover any Medicare Part D Drug or Medicare Part D covered supply or equipment even if coverage is denied by the Medicare Part D Plan. For services never covered by Medicare, documentation of the Medicare denial is not required. For NMAP covered services, refer to individual 471 NAC chapters.
3-004.03C Provider Practices: It is the provider’s responsibility to protect the value of their services through the use of sound business practices. Providers can best protect themselves by adopting procedures which -

1. Seek assignment of proceeds of health insurance policies;
2. Seek assignment of the provider’s rights to institute legal recovery of medical expenses; or
3. Place liens against the outcome of third party resources (Exception: Waiver claims or professionals unable to file liens).

3-004.04 Medicare Part A & B Deductible and Coinsurance: Medicaid pays the deductible and coinsurance for Medicare-covered services. The Department accepts Medicare's utilization review and payment decisions for Medicare allowable fees, except that after crediting any amount received from Medicare for Medicare-covered services and crediting any amount received from any third party resource (TPR), Medicaid will pay the lesser of the Medicare or Medicaid allowable amount of any remaining amount due.

3-004.04A Medicare Part D Monthly Premium, Deductible, Co-Insurance and Coverage Gaps: Medicaid does not pay the premium, deductible, co-insurance or coverage gaps for Medicare Part D.

3-004.04B Medicare Part A Coinsurance for Nursing Facility Services: For nursing facility services covered under Medicare Part A, Medicaid payments are limited to rates and payments according to the following method:

1. If the Medicare payment amount for a claim exceeds or equals the Medicaid rate or payment for that claim, Medicaid reimbursement will be zero (0).

2. If the Medicaid rates and payments for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

   a. The difference between the Medicaid rates and payments minus the Medicare payment amount; or
   b. The Medicare coinsurance and deductible, if any, for the claim.

3-004.05 Provider Payment in Full: Medicaid payment is the lower of the provider’s usual and customary charge or the Medicaid allowable less all third party payment. When a claim is submitted to Medicaid with a payment from a third party resource, the provider is considered paid in full when payment from the third parties and/or Medicaid equals or exceeds the Medicaid allowable amount. The provider may only bill the client for a Medicaid noncovered service, or Medicaid copayment fees, where applicable, or if the client has received payment from the TPR.
3-004.05A Medicare Part A & Part B: NMAP payment of Medicare coinsurance and deductible constitutes payment in full. The provider shall not balance bill.

3-004.05B Medicare Advantage: NMAP payment of Medicare Advantage coinsurance and deductible constitutes payment in full to the provider. The provider shall not balance bill.

3-004.05C Medicare Part D: NMAP does not pay premiums, deductible, co-insurance or coverage gaps for Medicare Part D.

3-004.05D Medicare Waiver of Liability: When a Medicare/Medicaid client signs a Medicare Waiver of Liability and Medicare denies the claim as "not reasonable and necessary," NMAP will not pay the claim.

3-004.05E Use of Contracts by Medicare/Medicaid Beneficiaries: If providers negotiate private contracts with Medicare/Medicaid beneficiaries for which no claim is to be submitted to Medicare and for which the provider receives no reimbursement from Medicare directly, neither Medicare nor Medicaid would cover the services provided under the private contract.

3-004.05F Casualty Settlements With a Third Party Resource: When a provider enters into an agreement with a Medicaid client or a representative of the client to accept less than billed charges, the provider is considered paid in full. No further payment is due from either the client or NMAP.

3-004.05G Provider's Failure to Cooperate in Securing Third Party Payment: The provider's failure to file necessary claims for TPR (except waiver claims) or to cooperate in securing payments by other third party resources are grounds for denial of the claims. If NMAP denies claims for these services, the client cannot be billed unless the payment went to the client.
3-004.06  Filing Claims with TPR

3-004.06A  Waiver of Cooperation for Good Cause:  With respect to obtaining medical care support and payments or identifying and providing information to assist the State in pursuing liable third parties for a child for whom the individual can legally assign rights, the Department must find that cooperation is not in the best interests of the individual or the person to whom Medicaid is being furnished because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person (see 466 NAC 1-006.04).

3-004.06B  Timely Filing of Claims with Health Insurance:  Providers shall first submit all claims to third party resources.  To secure a provider's right to Medicaid consideration for payment, a claim must be filed within 12 months from service date even if the TPR has not been resolved.  If the provider fails to submit a claim or fails to contact the COB Unit within 12 months from the date of service, NMAP will not pay the claim.

If the provider filed a claim with NMAP within 12 months of the date of service and received a Medicaid denial due to the existence of a third party resource, the provider is allowed up to 12 months from the original receipt date of the Medicaid claim to resolve the third party resource.  The provider shall submit the claim to NMAP within six months of the date on the insurance or Medicare remittance advice no later than 12 months from the original receipt date of the Medicaid claim.

3-004.06C  Timely Filing of Claims with Casualty Insurance:  Providers must submit claims within 24 months of the date of service.  In some casualty third party situations, the Department recognizes that it may take longer than 24 months to resolve the third party obligation.  In these situations, the Department can make payment beyond the 24 months if the provider can document that action was taken to obtain payment from the third party.  If a provider has received a denial from NMAP due to the existence of casualty insurance coverage and the provider has sought payment from the third party, then the provider can request the Department to reconsider payment if the provider has waited 24 months and the third party has not paid the provider.  If the provider has filed a lien, then the provider shall release its lien upon receipt of payment from NMAP.  These situations are reviewed on a case by case basis.
3-004.06D  Filing Medicaid Claims After Resolving Third Party Resources: Providers shall bill NMAP only when all third party resources have failed to cover the service or when a portion of the cost of the service has been paid. The provider must submit the third party documentation (such as the remittance advice, letter of denial, letter from attorney, or copy of check) with each claim submitted to the Department. The dates of service on the third party documentation must match the dates of service on each claim.

When billing NMAP, the provider shall bill the usual and customary charge for each service. The provider shall not submit a claim showing only the Medicaid allowable amount or the difference between the Medicaid allowable amount and the amount of the third party payment.

If after the provider has submitted a claim with the third party resource documentation and NMAP has adjudicated the claim for payment and the provider wishes to request an adjustment, the provider must submit the adjustment request within 90 days from the payment date on the Remittance Advice.

3-004.06D1  TPR Denials

3-004.06D1a  Health Insurance Denials: NMAP will recognize and consider payment on claims the health insurance has denied with a valid health insurance denial. A valid health insurance denial may include, but is not limited to, the following reasons:

1. Deductible was applied to dates of service on this claim;
2. Coverage was not in effect for this client on dates of service;
3. Client was never covered;
4. Annual or lifetime maximum allowable for the services has been exhausted during or prior to dates of service; or
5. Non-covered service based on policy exclusions.
3-004.06D1b Medicare Denials: NMAP will recognize and consider payment on claims Medicare has denied when the claim is submitted with a valid Medicare denial. A valid Medicare denial may include, but is not limited to, the following reasons:

1. Coverage was not in effect for this client on dates of service;
2. Client was never covered by Medicare;
3. Non-covered procedure; or
4. Item or service is never covered by Medicare.

NMAP may not consider payment for services that have been denied by Medicare for lack of medical necessity.

3-004.06D1c Casualty Insurance Denials: NMAP will recognize and consider payment on claims involving casualty coverage denial, when the claim is submitted with a valid casualty denial. A valid casualty insurance denial may include, but is not limited to, the following reasons:

1. Services not related to the incident;
2. Coverage not in effect; or
3. Coverage limits exhausted for all coverage types available and with all insurance carriers obligated.

The insurer's statement that payment cannot be made at this time due to a pending liability determination or litigation is not a valid denial. Information is provided on Form MCP 575, “Casualty Insurance Information Sheet.

3-004.06D2 Filing Electronic Claims with Third Party Resources: Medicaid will accept electronic claims when third party resources (health insurance and/or Medicare coverage) are available. The health insurance and/or Medicare documentation is required. (See 471-000-103.)
3-004.06D2a Automatic Transfer of Claims From Medicare: NMAP accepts Medicare crossover claims directly from Medicare's fiscal intermediaries and will pay the deductible and coinsurance when no additional third party resource is identified. Claims received from Medicare must include Medicare supplemental insurance coordination of benefits/remittance advice documentation, if applicable.

3-004.06E Third Party Resource Reversal of Payment to Provider: If a provider filed a claim with a third party resource and received payment in full, and thus did not bill Medicaid, and the third party resource reverses its determination after 12 months from the date of service, the provider may bill NMAP for the services. The provider shall bill NMAP within 60 days from the date on the third party reversal document and refund. The provider shall submit documentation of the reversal with the claim. The claim may be considered for payment by NMAP only if the date of service is no more than 24 months from the date of receipt of claim.

3-004.06F Prior Authorization and Third Party Resources: The provider shall resolve all third party resources before Medicaid can consider paying a claim even when Medicaid prior authorization has been given.

3-004.06G Client's Medicaid Eligibility and Third Party Resources: The provider shall resolve all third party resources before Medicaid can consider paying a claim even though the client is eligible for Medicaid. (Exception: Waiver claims - see 471 NAC 3-004.03A.) A client's eligibility for NMAP does not guarantee payment of a claim.

3-004.07 Long Term Care Insurance Policies: A long term care indemnity policy is considered a health insurance policy when the policy -

1. Allows assignment of benefits; and
2. Covers medical care based on specified criteria.

Long Term Care insurance which meets this criteria is not considered income for eligibility determination.

Because nursing facility claims are included in the category of "waiver claims," NMAP will pay these claims at the specific per diem for the client less any excess income/share of cost the client is obligated to pay the provider for the monthly services. The COB Unit will seek recovery on all of these policies. Because the claims have been paid, the provider shall not bill the insurer. The provider shall assist the COB Unit in obtaining reimbursement from these policies by furnishing any medical documentation the insurer requests.
A provider may choose to bill the long term care insurance; in these situations, the provider does not bill Medicaid.

If the provider or the client receives a payment directly from the insurer, the payment shall be sent to the COB/TPL Unit.

Whenever the Department receives any payments from long term care insurance which exceed what Medicaid has paid toward the care of the client, the Department shall apply the excess to any Medicaid expenditure for that Medicaid client even if the expenditure was not covered by the third party. The application of the excess TPL payment is not limited to a particular Medicaid service and can be applied to any claims for that Medicaid client paid by Medicaid. After the excess TPL payment has been applied to all claims, any remaining amount shall be paid to the client.

3-004.08 Medical Support from Non-Custodial Parents: When children with a non-custodial parent become Medicaid eligible, medical support is court ordered in compliance with Omnibus Budget Reconciliation Act 1993 (OBRA '93). The County Attorney's staff or Child Support Enforcement staff shall notify the COB/TPL Unit of any health insurance coverage and/or Medical Support Court Orders obtained for a child who is eligible for Medicaid. When a non-custodial parent is ordered by the court to furnish health insurance and/or make payment for medical services the provider may bill Medicaid for the services if the provider has not received payment from the health insurer or non-custodial parent within 30 days of the date of service. Medicaid shall pay the claims and the COB/TPL Unit shall seek recovery from the health insurer or non-custodial parent.

To determine whether a court order exists, the provider may contact the COB/TPL Unit. The provider is not required to continue to seek payment from the health insurer or non-custodial parent before billing Medicaid when there is court-ordered medical support.

Non-custodial parent medical support court orders may include an obligation by the non-custodial parent to pay a percentage of medical expenses after the health insurer has made payment. The provider is not required to seek payment from the non-custodial parent in these cases. If the provider receives a payment from a non-custodial parent, the provider shall indicate this amount and the amount received from the health insurer as a prior payment or amount paid on the claim submitted to Medicaid. The provider shall submit with the claim a copy of the documentation showing the non-custodial parent made the payment. If the provider receives payment from the non-custodial parent after Medicaid has paid the claim, the provider shall refund Medicaid according to 471 NAC 3-004.10A.

3-004.08A Health Insurer Obligation When Non-Custodial Parent Has Medical Support Court Order: A health insurer may not deny a child insurance coverage if the non-custodial parent has a court or administrative order for medical support. An insurer shall provide custodial parents information to file claims; allow the custodial parent or provider to file claims; and pay claims to the custodial parent, provider, or the Department, as required by Neb.Rev.Stat. Section 44-3,149. If the provider receives a denial of insurance coverage for any of these reasons from an insurer and the client is a child, the provider shall contact the COB/TPL Unit.
3-004.09 Provider Refunds to the Department: When a provider receives payment from a third party resource on a claim previously paid by NMAP, the provider shall submit a refund to the Department. The provider shall include the third party documentation, such as a remittance advice or coordination of benefits, letter from an attorney or copy of a check, with the refund. If the payment from the third party resource equals or exceeds the Medicaid payment on the claim, the total Medicaid payment must be refunded to the Department. If the payment from the third party resource is less than the Medicaid payment on the claim, the total third party payment must be refunded to the Department.

Note: The Department may request NE Point of Purchase (NE-POP) pharmacy providers to void claims through the NE-POP system instead of submitting refunds.

If, after NMAP has paid, a provider learns of a third party resource which would have paid more for the service than NMAP's allowable, in cases where health insurance is the third party resource, the provider may supply the COB Unit with the third party resource information, refund the Department the full NMAP payment, and then seek recovery from the third party resource. If a Medicaid client becomes retroactively eligible for Medicare, the provider shall refund the Department the full NMAP payment and seek reimbursement from Medicare for payment unless Medicare filing time limits for dates of service on the claims have been exhausted. In cases where casualty insurance is the third party resource, the provider shall not refund Medicaid's payment and then seek recovery from a third party resource, unless the refund is requested by the Department.

3-004.09A Department Requests for Refunds: When the Department receives information that the provider has received a third party resource payment on a Medicaid paid claim, the Department shall notify the provider that a refund is due to the Department. The provider is allowed 30 days to submit a refund check, show that the refund has already been made, document that the refund request is in error, or appeal. Failure to comply with this request within 30 days shall be cause for the Department to withhold future provider payments until the situation is resolved or impose sanctions on the provider. The refund request shall constitute notice of sanction.
3-004.10 Client Rights and Responsibilities

3-004.10A Client's Rights: A provider shall not refuse to furnish services to an individual who is eligible for Medicaid because of a third party’s potential liability for payment of service.

3-004.10B Client's Failure to Cooperate: A Medicaid client has the obligation to assist the provider and the Department in obtaining payment from all available third party resources. This may include complying with any requests from the insurer for additional information, ensuring that the provider or the Department receives remittance advice/coordination of benefits and/or payments from the insurer, or appearing in court in litigation situations. If the client fails to cooperate with the provider in securing third party resources, the provider may contact the COB/TPL Unit. Failure by the client to cooperate may cause the client to lose his/her Medicaid eligibility. The client will be responsible for charges on the denied services.

3-004.10C Client Responsibility When Enrolled in HMO or PPO Plan: Clients are required to utilize the services provided through and to obtain all necessary prerequisites as set out by the HMO or PPO plan (e.g., obtaining prior authorizations, using network providers, etc.). Failure to do so is considered lack of cooperation and will result in loss of Medicaid eligibility. The client is responsible for the charges on the denied services.

3-004.10D Client Responsibility When Health Insurance Premiums are Paid by the Department: If the Department determines it is cost effective to pay the premiums for a Medicaid eligible client to maintain their current commercial insurance coverage, the client shall follow any preauthorization or referral provisions of the plan or utilization of specific providers in the network. Claims denied by TPR because client did not utilize a network provider or obtain necessary authorizations or referrals will not be paid by Medicaid. The client will be responsible for the charges on the denied services.

3-004.10E Client Responsibility When Client Chooses to Enroll in Medicare Advantage (Medicare C) Plans: Medicaid will not pay claims denied by Medicare for Medicaid clients enrolled in Medicare Advantage plans who move out of the service area without complying with notification requirements. The client will be responsible for the charges on the denied services.

Claims denied by the Medicare Advantage plan because the client did not utilize a network provider or obtain necessary authorizations or referrals will not be paid by Medicaid.
3-004.11 Nebraska Medicaid Managed Care and Health Third Party Resources: Medicaid clients with Medicare or private health insurance determined to be "qualified coverage" (as indicated in 482 NAC 2-000 ff. such as full commercial coverage, HMO plans, or PPO plans) are excluded from mandatory participation in the Nebraska Health Connection. If a client becomes enrolled in both NHC and Medicare and/or a private insurance plan at the same time, the provider should contact the NHC plan on coordination of benefits issues.

The provider shall obtain prior authorization and/or referrals from all third party resources to avoid nonpayment. If the provider has difficulty obtaining third party payment or denials from the commercial plan and the policyholder is a non-custodial parent, the provider may contact COB staff for review on a case-by-case basis.

If the provider receives reimbursement from commercial insurance and/or Medicare while the client is enrolled in an NHC plan, the provider shall refund the NHC plan. Medicaid is refunded when the service was paid "fee for service" by NMAP as an exception (as indicated in 482 NAC 2-000).
3-004.12 Coordination of Benefits with Health Plans and Self-funded Insurers: These regulations implement Neb. Rev. Stat. §§ 68-926 to 68-933 governing coordination of benefits between licensed and self-funded insurers and the Nebraska Medicaid Program.

3-004.12A Definitions:

Coordinate benefits means:

1. Provide to the Department of Health and Human Services information regarding the licensed insurer's or self-funded insurer's existing coverage for an individual who is eligible for a state benefit program; and
2. Meet payment obligations to providers of health care services on behalf of Medicaid clients.

Coverage information, for other than limited benefit policies, means health information possessed by a licensed insurer or self-funded insurer that is limited to the following information about an individual:

1. Eligibility for coverage under a health plan;
2. Coverage of health care under the health plan; or
3. Benefits and payments associated with the health plan.

Coverage information for limited benefit policies means whether an individual has coverage, and, if so, a description of that coverage.

Department means the Department of Health and Human Services.

Health plan means any policy of insurance issued by a licensed insurer or any employee benefit plan offered by a self-funded insurer that provides for payment to or on behalf of an individual as a result of an illness, disability, or injury or change in a health condition.

Individual means a person covered by a state benefit program, including Medicaid, or a person applying for coverage under a state benefit program.

Licensed insurer means any insurer, except a self-funded insurer, including a fraternal benefit society, producer, or other person licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of Nebraska.
Limited benefit policy means a policy of insurance issued by a licensed insurer that consists only of one or more, or any combination of the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage for specified disease or illness; or
3. Hospital indemnity or other fixed indemnity insurance.

Medicaid means the medical assistance program established under Neb. Rev. Stat. §§ 68-901 to 68-949.

Self-funded insurer means any employer or union who provides a self-funded employee benefit plan.

3-004.12B Coverage Information Requests: The Department may request coverage information from a licensed insurer or a self-funded insurer about a specific individual without the individual’s authorization to:

1. Determine an individual’s eligibility for state benefit programs, including Medicaid; or
2. Coordinate benefits with state benefit programs.

The Department will specify the individual recipients for whom information is being requested.

3-004.12B1 Response to Requests: Self-funded insurers and licensed insurers must respond within 30 days of receipt of any request for coverage information from the Department, sent by first class mail. The information must be provided within thirty days after the date of the request unless good cause is shown.

3-004.12C Failure to Acknowledge and Respond to Coverage Information Requests

3-004.12C1 If a licensed insurer fails to acknowledge and respond to a request from the Department for coverage information about an individual, the Department will refer the insurer’s failure to respond to the Department of Insurance under the Unfair Insurance Claims Settlement Practices Act.

3-004.12C2 If a self-funded insurer fails to acknowledge and respond to a request from the Department for coverage information about an individual, the Department may find this a violation of the requirements of 471 NAC 3-004.12B and impose a civil money penalty.

3-004.12C3 Civil Money Penalty: The Department may impose and collect a civil money penalty on a self-funded insurer who fails to respond to a
coverage information request under 471 NAC 3-004.12B if the Department finds that the self-funded insurer:

1. Committed the violation flagrantly and in conscious disregard of the requirements; or
2. Has committed violations with such frequency as to indicate a general business practice to engage in that type of conduct.

3-004.12C3a The Department may impose a civil money penalty of no more than $1,000 for each violation, not to exceed an aggregate penalty of $30,000, unless the violation by the self-funded insurer was committed flagrantly and in conscious disregard of 471 NAC 3-004.12B in which case the penalty will not be more than $15,000 for each violation, not to exceed an aggregate penalty of $150,000.

3-004.12C3b To assess a penalty, the Department will:

1. Provide written notice of the violation to the self-funded insurer. The notice will specify:
   a. The total amount of the civil money penalty;
   b. The evidence on which the civil money penalty is based;
   c. That the self-funded insurer may request, in writing, a hearing to contest the assessment of a civil money penalty in accordance with 465 NAC 6-000; and
   d. That an unpaid civil money penalty constitutes a debt to the State of Nebraska which may be collected in the manner of a lien, foreclosure, or sued for and recovered in a proper form of action in the name of the state in the District Court of the county in which the violator resides or owns property; and
2. Send by certified mail, a written notice of the civil money penalty to the last known address of the person to whom the penalty is assessed.

3-004.12C3c The Department is authorized to recover all amounts paid or to be paid to state benefit programs as a result of failure to coordinate benefits by a licensed insurer or a self-funded insurer.

3-004.12C3d The Department will submit all money collected as a civil penalty under 471 NAC 3-004.12C3 to the State Treasurer, for distribution pursuant to Article VII, Section 5 of the Constitution of Nebraska.

3-004.12D Hearing: A licensed insurer or a self-funded insurer’s request for a hearing to appeal an action by the Department must comply with 465 NAC 6-000.
3-005 Prior Authorization: The Department is responsible for ensuring the appropriate expenditure of NMAP funds for medically necessary services provided to eligible clients. Prior authorization of payment for specific covered services, as a utilization control tool, is one method used to meet this responsibility. The Department uses prior authorization to:

1. Safeguard against unnecessary or inappropriate care and services;
2. Safeguard against excessive payments;
3. Assess the quality and timeliness of service;
4. Determine if less expensive, alternative care, services, or supplies could be used;
5. Promote the most effective and appropriate use of available services and facilities; and
6. Eliminate misutilization practices of providers and clients.

3-005.01 Services Requiring Prior Authorization: Services which require prior authorization of payment, prior authorization requirements, and methods are listed in the chapter of the Nebraska Department of Health and Human Services Finance and Support Manual related to the specific type of service.

3-005.02 Limitations of Prior Authorization: Prior authorization is issued only if the client is or was eligible for NMAP for the period for which services are authorized. If the client becomes ineligible for NMAP (through spend-down, suspension, or closing of the case) during the authorization period, the authorization is invalid in the period of ineligibility. The authorizing agent shall not submit a prior authorization request until eligibility for NMAP has been determined. Prior authorization is not transferable to other clients or other providers.

3-005.02A Medicare/Medicaid Eligibility: If the client is eligible for Medicare as well as Medicaid and the requested services are covered by Medicare, prior authorization is not issued. In some cases, as defined in the specific service policy, the provider must receive a denial of coverage from Medicare before a prior authorization is issued. The provider shall submit a copy of the denial with the claim form to receive payment.

3-005.03 Notification of the Client: The provider or local office shall notify the client of approval or denial of prior authorization according to the prior authorization procedures under the individual chapters of this Title.

3-006 (Reserved)

3-007 (Reserved)
3-008 Copayments

3-008.01 Copayment Schedule: The Department has established the following schedule of copayments for Medicaid services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount of copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Office Visits</td>
<td>$1 per visit</td>
</tr>
<tr>
<td>Dental Services</td>
<td>$3 per specified service</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$3 per specified service</td>
</tr>
<tr>
<td>Drugs (except birth control)</td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$2 copay</td>
</tr>
<tr>
<td>Brand name drugs</td>
<td>$3 copay</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>$2 per frames, lens, or frames with lens</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$3 per hearing aid</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$15 per admission</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse Visits</td>
<td>$2 per specified service</td>
</tr>
<tr>
<td>Occupational Therapy (non-hospital based)</td>
<td>$1 per specified service</td>
</tr>
<tr>
<td>Optometric Office Visits</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Physical Therapy (non-hospital based)</td>
<td>$1 per specified service</td>
</tr>
<tr>
<td>Physicians (M.D.'s and D.O.'s) Office Visits</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>(Excluding Primary Care Physicians Family Practice, General Practice, Pediatricians, Internists, and physician extenders (including physician assistants, nurse practitioners, and nurse midwives) who provide primary care services)</td>
<td></td>
</tr>
<tr>
<td>Podiatrists Office Visits</td>
<td>$1 per visit</td>
</tr>
<tr>
<td>Speech Therapy (non-hospital based)</td>
<td>$2 per specified service</td>
</tr>
</tbody>
</table>

Note: See 471-000-126 for a list of procedure codes for the services that are subject to copayment requirements. Drug products exempted from the copayment requirements are indicated on the Department's Drug Name/License Number Listing microfiche.

3-008.01A Excluded Services: The following services are excluded from the above copayment requirement by federal regulations:

1. Emergency services provided to treat an emergency medical condition in a hospital, clinic, office or other facility that is equipped to provide the required care. An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, that a prudent lay person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman and her unborn child) afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person; and
2. Family planning services, supplies, and drugs (such as contraceptive pills, creams, lotions etc.) provided to individuals of child-bearing age.
3-008.02 Covered Persons: All Medicaid-eligible adults age 19 or older listed below are subject to the copayment requirement:

1. Adults eligible under the Aid to Dependent Children (ADC) program;
2. Adults eligible under the Aid to Aged, Blind, and Disabled (AABD) program;
3. Adults eligible under the Refugee Resettlement Program (RRP);
4. Individuals who are receiving extended assistance for former Department wards; and
5. Individuals age 19 and 20 eligible under the Ribicoff program.

The client's Medicaid eligibility document will indicate whether the client is subject to the copayment requirement. The provider may also verify the client's copayment status by contacting the Nebraska Medicaid Eligibility System (NMES) or by using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see 471-000-50 Electronic Transactions Instruction).

3-008.02A Change in Client's Copayment Status During the Month: The client's copayment status may change during the month. If the client's copayment status changes during the month (for example, admission to a medical institution or alternate care as defined in 471 NAC 3-008.02B, or verification of pregnancy), the provider may submit documentation regarding copayments made or collected erroneously and the Department will make the appropriate adjustments to the claim. The provider shall refund the client (either cash or credit) when a copayment is erroneously collected. Providers may contact the Nebraska Medicaid Eligibility System (NMES) or use the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to verify the client's copayment status.

3-008.02B Exempted Persons: The following individuals are exempted from the copayment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);
3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;
4. Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes; and
5. Indians who receive items and/or services furnished directly by an Indian Health Care Provider or through referral from an Indian Health Care Provider under contract health services.
4. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Mental Retardation or Related Conditions; the Home and Community-Based Waiver for Children with Mental Retardation and Their Families; the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities or the Early Intervention Waiver;
5. Individuals with excess income (over the course of the excess income cycle, both before and after the obligation is met); and
6. Individuals who receive assistance under the State Disability Program (SDP).

3-008.03 Client Rights and Responsibilities: Clients listed in 471 NAC 3-008.02 as covered persons are required to pay the provider the applicable copayment amounts as specified in 471 NAC 3-008.

If a client believes that a provider has charged the client incorrectly, the client must continue to pay the copayments charged by that provider until the Department determines whether the copayment amounts are correct.

The client has the right to appeal under 465 NAC 2-001.02.
3-008.04 Collection of Copayment: The provider shall collect the copayment from the client when the service is provided. The provider shall not refuse to provide services to the client if the client is unable to pay the copayment amount at the time of the service. This does not alleviate the client's liability for the copayment amount nor does it prevent the provider from attempting to collect the copayment amount.

If it is the routine business practice of the provider to refuse service to any individual with uncollected debt, the provider may include uncollected copayments under this practice. Providers shall give sufficient notice to the client before services can be denied.

Providers shall bill their usual and customary charge regardless of whether the copayment has been collected. The provider shall not enter the copayment as a "prior payment or amount paid" amount on the claim.

A provider shall not establish a policy to automatically waive copayments or deductibles established by the Department. A provider shall not advertise or promote through newspapers, magazines, circulars, direct mail, directories, radio, television, or otherwise that the provider will waive the collection of all or any portion of the required copayments or deductibles.

The provider shall not collect a copayment amount that exceeds the provider's usual and customary charge or the NMAP payment. Copayment collected from the client must be the lowest of the established copayment amount, the provider's usual and customary charge, or the NMAP payment.

Also see 471 NAC 3-008.02A.

3-008.05 Third Party Liability: For Medicaid clients enrolled in commercial HMO or PPO plans, the Medicaid copayment may apply.

3-008.06 Medicare: For Medicare/Medicaid eligible clients, the Medicaid copayment applies. NMAP pays Medicare co-insurance and deductible amounts on Medicare-approved services minus any Medicaid copayment.
CHAPTER 4-000 AMBULANCE SERVICES

4-001 Definitions:

Advanced Life Support (ALS) Services: Transportation by ground ambulance vehicle and the provision of medically necessary services by ALS personnel; and if necessary, the use of medically necessary complex specialized life sustaining equipment and, ordinarily, equipment for radio-telephone contact with a physician or hospital.

ALS Personnel: Personnel trained and authorized to provide specialized services such as administering IV's (intravenous therapy), establishing and maintaining a patient's airway, defibrillating the heart, relieving pneumothorax conditions, and performing other advanced life support procedures or services such as cardiac (EKG) monitoring.

Basic Life Support (BLS) Services: Transportation by ground ambulance vehicle and the provision of medically necessary services plus the equipment and staff needed for basic services such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, cardio-pulmonary resuscitation (CPR), defibrillation, etc.

Contraindication: Any circumstance, symptom, or condition that renders a particular medical treatment improper or undesirable.

Emergency Transport: Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the client's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Hospital Based Ambulance Service: An ambulance service which is owned and operated by a hospital.

Loaded Mileage: Miles traveled while the client is present in the ambulance vehicle.

4-002 Provider Requirements:

4-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of ambulance services shall comply will all applicable provider participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 4, the individual provider participation requirements in 471 NAC Chapter 4 shall govern.
4-002.02 Service Specific Provider Requirements: To participate in Medicaid, providers of ambulance services shall meet the licensure and certification requirements of the Nebraska Department of Health and Human Services, Division of Public Health. Out-of-state ambulance providers shall meet the licensure and certification requirements of that state, and be enrolled in Nebraska Medicaid by complying with the Provider Agreement requirements included in 471 NAC 4-002.02A.

4-002.02A Provider Agreement: The ambulance provider shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

4-002.02B Vehicular Specifications and Requirements: The ambulance vehicle must be specially designed and equipped for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, and oxygen equipment, and it must also have such other safety and lifesaving equipment as is required by state or local authorities. A wheelchair van is not considered an ambulance vehicle and therefore cannot provide ambulance services.

4-003 Service Requirements:

4-003.01 General Requirements:

4-003.01A Medical Necessity of the Service: 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. Claims for ambulance services must include adequate documentation for determination of medical necessary.

4-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

4-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

4-003.02 Covered services: Medicaid covers medically necessary and reasonable ambulance services required to transport a client to obtain, or after receiving, a Medicaid covered service.

4-003.02A Ground Ambulance Services

4-003.02A1 Basic Life Support (BLS) Services: Medicaid covers BLS ambulance services as defined in 471 NAC 4-001.

4-003.02A2 Advanced Life Support (ALS) Services: Medicaid covers ALS ambulance services as defined in 471 NAC 4-001.
(i) ALS transports with specialized ALS services are covered only when ambulance personnel perform specialized ALS services during the transport (e.g., start IV medication, establish patient's airway, etc.).

(ii) ALS transports with no specialized ALS services are covered only when ambulance personnel monitor specialized ALS services during the transport but do not actually render the services.

(iii) If ALS services are not provided or monitored during the ALS transport, the services are covered as a BLS service.

4-003.02A3 Mileage: Loaded mileage is covered for total distances in excess of five (5) loaded miles. Unloaded mileage, and the initial five (5) loaded miles when the total distance is not in excess of five (5) loaded miles, is covered as a part of the base rate outlined in 471 NAC 4-004.02B1.

4-003.02A4 Third Attendant: A third attendant is covered only if the circumstances of the transport require three attendants. Payment for a third attendant cannot be made when the third attendant is:

1. Needed because a crew member is not qualified to provide a service (e.g., administer IV's, etc.); or
2. Staff provided by the hospital to accompany a client during transport.

The circumstances which required the third attendant must be documented on or with the claim when billing NMAP.

4-003.02A5 Waiting or Standby Time: Waiting or standby time under normal circumstances is covered as a part of the base rate outlined in 471 NAC 4-004.02B1. Waiting or standby time, beyond the first one-half hour, is covered separately only when unusual circumstances exist.

4-003.02B Air Ambulance: Medicaid covers medically necessary air ambulance services only when transportation by ground ambulance is contraindicated and—

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

4-003.02C Non-emergency Transports: Any ambulance transport that does not meet the definition of an emergency transport, included in 471 NAC 4-001, will be covered as a non-emergency transport. This includes all scheduled runs (regardless of point of origin and destination), hospital to hospital transports, and transports to nursing facilities or to the client's residence. Although non-emergent, these transports are covered in accordance with this 471 NAC Chapter 4. Sufficient documentation is required to support the medical necessity of a non-emergency transport.
4-003.02C1 Transports to the Facility Which Meets the Needs of the Client: Ambulance services are covered to enable the client to obtain medical care in a facility or from a physician/practitioner that most appropriately meets the needs of the client, including:

(i) Support from the client's community and/or family; or
(ii) Care from the client's own physician/practitioner or a qualified physician/practitioner and/or specialist (e.g., to establish or maintain a "medical home").

Non-emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered when:

(i) The client is bed confined before, during, and after transport; and
(ii) The services cannot or cannot reasonably be expected to be provided at the client's residence (including a nursing facility or Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD)).

4-003.02D Round Trip Transports for Hospital Inpatients: Ambulance services provided to a client receiving inpatient hospital services, where the client is transported to a separate facility for services (e.g., diagnostic testing), and the client is returned to the originating hospital for continuation of inpatient care, are covered as an ambulance service as opposed to a hospital service outlined in 471 NAC Chapter 10.

4-003.02E Transport of More Than One Client: When more than one client is transported during a single trip, a base rate is covered for each client transported. The number of loaded miles and mileage charges must be prorated among the number of clients being billed.

4-003.02F Transport of Medical Teams: Transportation of a medical team (or other medical professionals), resulting in an ambulance transport of the client, is covered as a part of the base rate outlined in 471 NAC 4-004.02B1. Transportation of a medical team without the client being in the ambulance is not covered.

4-003.02G Transport of Deceased Clients: Ambulance services are covered if the client is pronounced dead while en route to or upon arrival at the hospital. Ambulance services are not covered if a client is pronounced dead before the client is transported.

4-003.02H Hospital-Based Ambulance Service: Hospital-based ambulance services are regulated in 471 NAC Chapter 10. Refer to 471 NAC Chapter 10 for all coverage limitations, billing requirements, and payment limitations.

4-004 Billing and Payment for Ambulance Services

4-004.01 Billing
4-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that individual billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 4, the individual billing requirements in 471 NAC Chapter 4 shall govern.

4-004.01B Specific Billing Requirements

4-004.01B1 Billing Instructions: The Provider shall bill Medicaid, using the appropriate claim form or electronic format (see Claim Submission Table at Appendix 471-000-49), in accordance with the billing instructions included in Appendix 471-000-53.

4-004.01B2 Usual and Customary Charge: The provider or the provider’s authorized agent shall submit the provider’s usual and customary charge for each procedure code listed on the claim. HCPCS procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see Appendix 471-000-504).

4-004.02 Payment

4-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that individual payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 4, the individual payment regulations in 471 NAC Chapter 4 shall govern.

4-004.02B Specific Payment Requirements

4-004.02B1 Base Rates: Ground ambulance base rates include all services, equipment and other costs, including: vehicle operating expenses, services of two attendants and other personnel, overhead charges (linens, etc.), reusable and disposable items and supplies, oxygen, pharmaceuticals, unloaded and five (5) or less total loaded mileage, and usual waiting/standby time.

4-004.02B2 Reimbursement: Medicaid pays for covered ambulance services at the lower of:
   1. The provider’s submitted charge; or
   2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule (Appendix 471-000-504) in effect for that date of service.

4-004.02B3 Air Ambulance: If a determination is made that ambulance transport is medically necessary, but ground ambulance would have been appropriate, payment for the air ambulance service is limited to the amount allowable for ground transport.
CHAPTER 5-000  CHIROPRACTIC SERVICES

5-001 Definitions

Initial Visit: History, examination, and manual manipulation for a client who has not received services from the chiropractor within the past three years.

5-002 Provider Requirements

5-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of chiropractic services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 5, the individual provider participation requirements in 471 NAC Chapter 5 shall govern.

5-002.02 Service Specific Provider Requirements: Chiropractors must be licensed by the Nebraska Department of Health and Human Services, and be eligible to participate in Medicare. If chiropractic services are provided outside of Nebraska, the chiropractor must be licensed in that state.

5-002.02A Provider Agreement: Chiropractors shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

5-003 Service Requirements

5-003.01 General Requirements

5-003.01A Medical Necessity: Treatment that is reasonable and necessary. Documentation of a reasonable expectation of recovery or improvement from ongoing chiropractic treatment is required.

5-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

5-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.
5-003.02 Covered Services: Medicaid limits coverage of chiropractic services to treatment of the spine by manual manipulation and certain spinal x-rays (see 471 NAC 5-003.02B).

5-003.02A Manual Manipulation: Manual manipulation of the spine is covered only for the treatment of spinal subluxations for which treatment provides a direct therapeutic benefit.
   1. For clients age 21 and older: Manual manipulation of the spine is limited to a maximum of 12 treatments per calendar year.
   2. For clients age 20 and younger: Manual manipulation of the spine is limited to a maximum of 18 treatments in the initial 5 months from the date of the first visit for the reported diagnosis. After the 5th month a maximum of one treatment per month is covered until the age of 21.
   3. No more than one treatment per client per day is covered.

5-003.02B Spinal X-Rays: Coverage of spinal x-rays is limited to one anteroposterior and one lateral view of the entire spine or each of the following: thoracic, cervical, and lumbosacral for a client in a 12 month period.

For spinal x-rays to be covered under Medicaid, at least one of the following criteria must be met:
   1. Recent acute or violent trauma where there may be a question concerning avulsion, fracture, or subluxation;
   2. Chronic or long-standing ailments that have been treated by other practitioners without success and, if x-rays were already taken, they are not available;
   3. When there is a pathology or malignancy previously diagnosed, precautionary x-rays are covered when medically necessary;
   4. If there is any indication of existing pathology in the evaluation of the client, the treatment of which may cause additional discomfort;
   5. If the client has been under long-term treatment with no alleviation of symptoms; or
   6. When specifically required by the Department's utilization review and for documentation of diagnosis and claims for services.

5-003.03 Non-Covered Services: Except for treatment of the spine by manual manipulation and spinal x-rays, Medicaid does not cover any other diagnostic or therapeutic service or supply provided by a chiropractor or on his/her order including, but not limited to:
   1. Laboratory tests;
   2. Orthopedic devices;
   3. Physiotherapy (i.e., ultrasound, diathermy, etc.);
   4. Nutritional supplements;
   5. EKGs; and
   6. Acupuncture.
5-004 Billing and Payment for Chiropractic Services

5-004.01 Billing

5-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in 471 NAC Chapter 5, the billing requirements in 471 NAC Chapter 5 shall govern.

5-004.01B Specific Billing Requirements

5-004.01B1 Billing Instructions: The provider shall bill Medicaid, using the appropriate claim form or electronic format (see Claim Submission Table at Appendix 471-000-49), in accordance with the billing instructions included in Appendix 471-000-54.

5-004.01B2 Usual and Customary Charge: The provider, or the provider's authorized agent, shall submit the provider's usual and customary charge for each procedure code listed on the claim. HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-505).

5-004.01B3 Manual Manipulation: The chiropractor shall list the following information on the claim when billing Medicaid:
   a. The diagnosis which includes the level of subluxation;
   b. The symptom(s) that directly relates to the diagnosis (subluxation); and
   c. The initial date of treatment billed to Medicaid for the reported diagnosis.

5-004.02 Payment

5-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 5, the payment regulations in 471 NAC Chapter 5 shall govern.

5-004.02B Specific Payment Requirements

5-004.02B1 Reimbursement: Medicaid pays for covered chiropractic services in amount equal to the lesser of:
   a. The provider's submitted charge; and
   b. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.
5-004.02B2  Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see Appendix 471-000-70.

5-004.02B3  Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.
CHAPTER 6-000 DENTAL SERVICES

6-001 Definitions

Adequate Occlusion for Partial Dentures: First molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion.

Handicapping Malocclusion: An improper alignment of the teeth due to one of two conditions:
  i. Craniofacial birth defect that is affecting the occlusion.
  ii. Mutilated and severe malocclusions.

Medicaid uses the Handicapping Labiobuccal Deviation (HLD) Index to determine whether coverage is appropriate based on a handicapping malocclusion. The HLD Orthodontic Diagnostic Score Sheet is included within 471-000-406, with a score of 28 or greater being necessary to qualify for Medicaid coverage of orthodontic treatment.

Occlusal Orthotic Device: Splints that are provided for treatment of temporomandibular joint dysfunction.

Special Needs: For the purposes of this Dental Services, a client with special needs is a client who is unable to care for his/her mouth properly on his/her own because of a disabling condition.

6-002 Provider Requirements:

6-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of dental services shall comply with all applicable participation requirements codified in 471 NAC Chapters 1, 2 and 3. In the event that participation requirements in 471 NAC Chapters 1, 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 6, the provider participation requirements in 471 NAC Chapter 6 shall govern.

6-002.02 Service Specific Provider Requirements: Providers of dental services must be licensed by the Nebraska Department of Health and Human Services as a dentist or a dental hygienist and must practice within their scope of practice as defined in Neb. Rev. Stat. Sections 38-1101 to 38-1151. If services are provided in another state, the dentist or dental hygienist must be licensed in that state, must practice within his/her scope of practice as defined by the licensing laws for that state, and must be enrolled in Nebraska Medicaid by complying with the Provider Agreement requirements included in 471 NAC 6-002.02A.

6-002.02A Provider Agreement: Providers of dental services shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the
completed form to the Nebraska Department of Health and Human Services for approval to participate in Medicaid.

6-003 Service Requirements

6-003.01 General Requirements

6-003.01A Medical Necessity: Dental services must be delivered in accordance with generally accepted, evidence-based medical standards. Dental services must be:

i. Reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition that endangers life, causes suffering or pain, or has resulted or will result in a handicap, physical deformity or malfunction;

ii. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment;

iii. The least costly service meeting the treatment needs. There can be no equally effective, more conservative, and less costly course of treatment available or suitable for the client.

iv. Within the scope of the coverage criteria contained in these regulations;

v. Within accepted dental or medical practice standards; and

vi. Consistent with a diagnosis of dental disease or condition.

Services may be subject to the specific limitations or prior authorization requirements as listed in 471 NAC 6-003.

6-003.01A1 Documentation of Medical Necessity: Documentation of medical necessity is required on all procedures. The documentation should be in the client’s dental chart which must be available to the Department upon request.

6-003.01B Prior Authorization: The provider must receive prior authorization before providing the following services:

i. Crowns. See 471 NAC 6-003.02C2 for specific documentation requirements.

ii. Periodontal Scaling and Root Planing. See 471 NAC 6-003.02E2 for documentation requirements.

iii. Periodontal Maintenance Procedure. See 471 NAC 6-003.02E4 for documentation requirements.

iv. Complete, Immediate and Interim Dentures (Maxillary and Mandibular). See 471 NAC 6-003.02F2, 471 NAC 6-003.02F3 and 471 NAC 6-003.02F10 for documentation requirements.

v. Partial Resin Base (Maxillary and Mandibular). See 471 NAC 6-003.02F4 for documentation requirements.

vi. Flipper Partial Dentures (Maxillary and Mandibular). See 471 NAC 6-003.02F11 for documentation requirements.

vii. Orthodontic Treatment. See 471 NAC 6-003.02H for documentation requirements.
Specific documentation must be submitted along with each prior authorization request. Submitted documentation that is inadequate, or does not otherwise meet the criteria for review, may be disapproved, or returned for additional information or correction.

6-003.01B1 Request for Prior Authorization: To request prior authorization for a proposed dental pre-treatment plan or covered service, the dentist must submit the request using one of the following options:
  a. Electronically using the standard Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);
  b. Submission of a dental claim form and required documentation:
     i. by mail to:
        Department of Health and Human Services
        Division of Medicaid and Long Term Care
        P. O. Box 95026
        Lincoln, NE 68509-5026;
     ii. by fax to: 402-742-8342; or
     iii. by email to: dhhs.medicaiddental@nebraska.gov.

Copies of documentation should be provided to the Department and original documentation should be retained by the Provider. Medicaid cannot guarantee the return of submitted original documentation.

6-003.01B2 Medicaid Eligibility: Providers shall re-check Medicaid client eligibility before starting a service, even with an approved prior authorization. Since Medicaid eligibility may vary from month to month, Medicaid cannot guarantee that the eligibility for a prior authorized patient will remain constant. If a client becomes ineligible for Medicaid benefits, the authorization becomes void.

6-003.01B3 Adult Emergency Dental Services / Extensive Treatment Circumstances: See 471 NAC 6-003.01C2 and 471 NAC 6-003.01C3 for service limitations. For planned services, the dental provider performing the service must complete and submit a prior authorization request form either by fax to (402) 742-8342 or mail (at the address in 6-003.01B1b) to the attention of the Dental Program Specialist. The request must clearly indicate that it is either an emergency services or extensive treatment circumstances request, and be accompanied by sufficient documentation to determine the emergent medical necessity. In the event that the service must be rendered immediately, the dental provider must submit a request for coverage, post treatment, with documentation of the emergent medical necessity, for payment review.

6-003.01C Services for Individuals Age 21 and Older: Dental coverage is limited to $750 per fiscal year. The annual limit is calculated at the Medicaid dental fee schedule rate for the treatment provided or on the all inclusive encounter rate paid to Indian Health Service (IHS) or Federally Qualified Health Centers (FQHC) facilities.

6-003.01C1 Providers Responsibility and Client Responsibility Regarding the Yearly Dental Limit: Providers must inform a client before treatment is provided of the client’s obligation to pay for a service if the client’s annual limit has already been reached or if the amount of treatment proposed will cause the client’s annual limit to be exceeded.
Also see 471 NAC 3-002.11, “Billing the Client”.

6-003.01C2 Emergency Dental Services: Adult dental services provided in an emergency situation are not subject to the annual per fiscal year limits imposed in 471 NAC 6-003.01C. Adult dental services provided in an emergency situation will be considered for coverage on a case-by-case basis. Only the most limited service(s) needed to correct the emergency condition will be covered. Medicaid will cover emergency dental services that were not prior authorized. The provider must submit a completed coverage request with supporting documentation of the emergent nature of the services provided. Medicaid considers the following conditions to be emergent:

a. Extractions for the relief of:
   i. Severe and acute pain; or
   ii. An acute infectious process in the mouth.

b. Extractions and necessary treatment for repair of traumatic injury;

c. Full mouth extractions as necessary for catastrophic illness such as an organ transplant, chemotherapy, severe heart disease, intra-oral radiation workup, or other life threatening illnesses.

6-003.01C3 Dentures and Extensive Treatment Circumstances: Medicaid will review, and consider coverage of, services that cause the client to exceed the annual coverage limit, where the client is in need of dentures and extensive treatment in a hospital setting due to a disease/medical condition, or the client is disabled and it is in the best interest of the client’s overall health to complete the treatment in a single setting. A prior authorization request must be submitted with medical necessity documentation.

6-003.01D Services Provided to Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

6-003.01E HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

6-003.01F Hospitalization or Treatment in an Ambulatory Surgical Center: Dental services must be provided at the least expensive appropriate place of service. For clients enrolled in Managed Care, see 471 NAC 6-003.01D.

6-003.01G Medical and Surgical Services of a Dentist or Oral Surgeon: Medically necessary services of a Dentist or Oral Surgeon not otherwise covered in this Chapter, are covered and reimbursed as a Physician’s Service in accordance with the 471 NAC Chapter 18. For clients enrolled in Managed Care see 471 NAC 6-003.01D.

6-003.02 Covered Services: Medicaid does not cover all American Dental Association (ADA) procedure codes. Covered codes are listed in the Medicaid Dental Fee Schedule in 471-000-506.

6-003.02A Diagnostic Services

6-003.02A1 Oral Evaluations: Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists. All oral examinations must be
provided by a dentist. A single exam code is covered per date of service. Not to be billed with any other exam codes on the same date of service.

6-003.02A1a Periodic Oral Evaluations: Covered as follows:

6-003.02A1a(i) Age 20 & Younger: Periodic oral evaluation is covered once every 180 days.

6-003.02A1a(ii) Age 21 & Older: Periodic oral evaluation is covered once every 180 days.

6-003.02A1a(iii) Special Needs and Disabled Clients: Periodic oral evaluation is covered at the frequency determined appropriate by the treating dental provider.

6-003.02A1a(iv) Documentation Requirements: Documentation of client's special needs or disability is required.

6-003.02A1b Limited Oral Evaluation: Limited to twice in a one year period for each client, and for treatment of a specific oral health problem or complaint. Documentation which specifies the medical necessity is required.

6-003.02A1c Oral Evaluation for Infant: Covered for clients age 3 and younger, includes counseling with the primary caregiver.

6-003.02A1d Comprehensive Oral Evaluation: Benefit is limited to one per three year period per client, per provider, and location. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.

6-003.02A1e Detailed and Extensive Oral Examination: Problem focused oral evaluation. Benefit is limited to one per three year period per client. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.

6-003.02A1f Re-Evaluation: Limited and problem focused. Benefit is limited to one per year per client.

6-003.02A1g Comprehensive Periodontal Evaluation: Benefit is limited to one per three year period per client.

6-003.02A2 Radiographs: Medicaid covers a “maximum dollar amount” for any combination of the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, or panorex. The maximum dollar amount covered is equal to the Medicaid fee paid for an intraoral complete series (see Appendix 471-000-72). A Cephalometric film is not included in the maximum dollar amount. Occlusal film (2 ¼ X 3 ¾ size): Medicaid covers:

a. Bitewings: A maximum of four bitewings per date of service.

b. Intraoral Complete Series: Covered every three years.
c. Panorex: Covered every three years. Covered more frequently if necessary for treatment.
i. Documentation Requirements: Document need for more frequent panorex in dental chart.
d. Cephalometric film: Covered for clients age 20 and younger, as follows:
i. Orthodontic Treatment: Covered if the client will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria (see 471 NAC 6-003.02G).

6-003.02A3 Diagnostic Casts: Covered for clients age 20 and younger as follows:
a. Orthodontic Treatment: Covered if the client will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria (see 471 NAC 6-003.02G).

6-003.02B Preventive Services

6-003.02B1 Prophylaxis: Prophylaxis procedures are covered at the frequency listed below:

6-003.02B1a Age 13 and younger - Covered one time every 180 days. Bill as a child prophylaxis

6-003.02B1b Age 14 through 20 - Covered every 180 days. Bill as an adult prophylaxis

6-003.02B1c Age 21 and Older - Covered one time every 180 days.

6-003.02B1d Special Needs Clients: Prophylaxis is covered at the frequency determined appropriate by the treating dental provider. Limited to one per date of service per client.

6-003.02B1d(i) Documentation Requirements: Documentation of client’s special needs or disability is required.

6-003.02B2 Topical Fluoride and Fluoride Varnish: Covered for adults and children at the frequency determined appropriate by the treating dental provider.

6-003.02B3 Sealants: Covered on permanent and primary teeth for clients ages 20 and younger. Covered once per tooth every 730 days.

6-003.02B4 Space Maintainers (Passive Appliances): Covered for clients age 20 and younger. Covered once every 365 days.

6-003.02B5 Recementation of Space Maintainers: Covered for clients age 20 and younger. Covered once every 365 days.
6-003.02C Restorative Services: Tooth preparation, temporary restorations, cement bases, pulp capping, impressions and local anesthesia are included in the restorative fee for each covered service.

6-003.02C1 Amalgam or Resin: Resin refers to a broad category of materials including but not limited to composites, and glass ionomers. Full Labial veneers for cosmetic purposes are not covered.

6-003.02C1a Documentation Requirements: Documentation of carious lesions must be present.

6-003.02C1b Maximum Fee: A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a four or more surface restoration.

6-003.02C2 Crowns: Covered for anterior and bicuspid teeth when other restoration is not possible. Covered for molar teeth that have been endodontically treated, and cannot be adequately restored with a stainless steel crown, amalgam or resin restoration. Not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who originally placed the crown.

6-003.02C2a Documentation Requirements: Submit x-ray of anterior and/or bicuspid, or x-ray of molar that shows completed root canal. A request should not be submitted for unusual or exceptional situations not covered herein.

6-003.02C3 Prefabricated Stainless Steel Crowns: Covered for primary and permanent teeth.

6-003.02C4 Prefabricated Stainless Steel Crown with Resin Window: Covered for primary anterior teeth.

6-003.02C5 Sedative Filling: Covered once per tooth every 365 days.

6-003.02C6 Unspecified Restorative Procedure, By Report: Used for procedures that are not adequately described by another code. This code shall not be used to claim an item that has an ADA code, but is not covered by Medicaid.

6-003.02C6a Documentation Requirements: A description of treatment provided must be submitted with the claim. This service is reviewed prior to payment.

6-003.02D Endodontics:

6-003.02D1 Therapeutic Pulpotomy and Pulpal Therapy: Covered for primary teeth only. Not covered for permanent teeth.
6-003.02D2 Root Canal Therapy and Re-treatment of Previous Root Canals: Covered for permanent teeth. Root canal treatment includes a treatment plan, necessary appointments, clinical procedures, radiographic images and follow up care. Re-treatment of previous root canals may be covered if at least 365 days have passed since the original treatment, and failure has been demonstrated with x-ray documentation and narrative summary.

6-003.02D2a Limitations: Not covered for third molars.

6-003.02D2b Documentation Requirements: Post-op x-ray of completed root canal must be available for review by Department upon request.

6-003.02D3 Apicoectomy: Covered on permanent anterior teeth.

6-003.02D4 Emergency Treatment to Relieve Endodontic Pain: Covered as “Unspecified Endodontic Procedure, By Report” code. Tooth number must be identified on the claim submission. Not to be submitted with any other definitive treatment codes on same tooth on same day of service.

6-003.02E Periodontics:

6-003.02E1 Gingivectomy or Gingivoplasty Per Tooth or Per Quadrant

6-003.02E2 Periodontal Scaling and Root Planing: Medicaid covers four quadrants of scaling and root planning once every 365 days. Each quadrant is covered one time per client. The request for approval must be accompanied by the following:
  i. A periodontal treatment plan;
  ii. A completed copy of a periodontic probe chart that exhibits pocket depths;
  iii. A periodontal history, including home oral care; and
  iv. Radiography.

6-003.02E2a Exclusions: For scaling and root planning that requires the use of local anesthesia, NE Medicaid does not cover more than one half of the mouth in one day, except on hospital cases.

6-003.02E2b Documentation Requirements: Submit with prior authorization request:
  i. Periapical x-rays demonstrating subgingival calculus and/or loss of crestal bone; and
  ii. Periodontal probe chart evidencing active periodontal disease and pocket depths of 4mm or greater.

A treatment plan that demonstrates that curettage, scaling, or root planning is required in addition to a routine prophylaxis.
6-003.02E3  Full Mouth Debridement: Medicaid covers one full mouth debridement procedure every 365 days per client. Not covered on the same date of service as prophylaxis.

6-003.02E4 Periodontal Maintenance Procedure: Covered for clients that have had Medicaid approved periodontal scaling and root planing. Prior authorization must be renewed annually.

6-003.02E4a Documentation Requirements: Submit with prior authorization request:
   i. Date the Medicaid approved scaling and root planing completed;
   ii. Periodontal history; and,
   iii. Frequency the dental provider is requesting that the client must be seen for maintenance procedure.

6-003.02F Prosthodontics: Medicaid covers the following prosthetic appliances, subject to service specific coverage criteria.
   i. Dentures (immediate, replacement/complete, or interim/complete);
   ii. Resin base partial dentures, including metal clasps;
   iii. Flipper partials (considered a permanent replacement of one to three anterior teeth only); and
   iv. Cast metal framework with resin denture base partials, covered for clients age 20 and younger.

Coverage of prosthetic appliances includes all materials, fitting and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.

6-003.02F1 Replacement: Replacement of any prosthetic appliance is covered once every five years when:
   a. The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client; and
   b. The client does not have a history of lost prosthetic appliances; and
   c. A repair will not make the existing denture or partial functional; or
   d. A reline will not make the existing denture or partial functional; or
   e. A rebase will not make the existing denture or partial functional.

Medicaid covers a one time replacement within the 5 year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each client's lifetime, and a prior authorization request must be submitted and marked as a one time replacement request.

6-003.02F2 Complete Dentures (Maxillary and Mandibular): Covered 180 days after placement of interim dentures. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis.
6-003.02F2a Documentation Requirements: Submit with prior authorization request:
   i. Date of previous denture placement;
   ii. Information on condition of existing denture; and
   iii. For initial placements, submit panorex or full mouth series radiographs.

6-003.02F3 Immediate Dentures (Maxillary and Mandibular): Considered a permanent denture. Relines or rebases are not billable for 180 days after placement of the prosthesis.

   6-003.02F3a Documentation Requirements: Submit with prior authorization request:
      i. Date and list of teeth to be extracted;
      ii. Narrative documenting medical necessity; and
      iii. Submit panorex or full mouth series radiographs.

6-003.02F4 Partial Resin Base (Maxillary or Mandibular): Covered if the client does not have adequate occlusion. Cast metal clasps are included on partial dentures. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.

   6-003.02F4a Documentation Requirements: Submit with prior authorization request:
      i. Chart or list of missing teeth and/or teeth to be extracted;
      ii. Age and condition of any existing partial, or a statement identifying the prosthesis as an initial placement;
      iii. Narrative documenting how there is not adequate occlusion; and
      iv. For initial placements, radiographs of remaining teeth are required.

6-003.02F5 Partial Cast Metal Base (Maxillary or Mandibular): Covered for clients age 20 and younger only. More than one posterior tooth must be missing for partial placement. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.

6-003.02F6 Adjustments – Dentures and Partial: Not covered for 180 days following placement of a new prosthesis. Adjustments after 180 days are billable as needed to make prosthesis wearable.

6-003.02F7 Repairs to Dentures and Partial: Medicaid covers 2 repairs per prosthesis every 365 days.

6-003.02F8 Rebase of Dentures and Partial: Covered following the placement of a new prosthesis after 180 days have passed. Covered once per prosthesis every 365 days. Chairside and lab rebases are covered, but only one can be provided within the 365 day period.
6-003.02F9 Reline of Dentures and Partials: Covered following the placement of a new prosthesis after 180 days have passed. Covered once per prosthesis every 365 days. Chairside and lab relines are covered, but only one can be provided within the 365 day period.

6-003.02F10 Interim Complete Dentures (Maxillary and Mandibular): Interim dentures can be replaced with a complete denture 180 days after placement of the interim denture. Complete dentures require prior authorization in accordance with 471 NAC 6-003.01B(iv) and are regulated under 471 NAC 6-003.02E2.

6-003.02F10a Documentation Requirements: Submit with prior authorization request:
   i. Date and list of teeth to be extracted;
   ii. Narrative documenting medical necessity; and
   iii. Submit panorex or full mouth series radiographs.

6-003.02F11 Flipper Partial Dentures (Maxillary and Mandibular): Considered a permanent replacement for one to three anterior teeth. Not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis.

6-003.02F11a Documentation Requirements: Submit with prior authorization request:
   i. Chart or list missing teeth and/or teeth to be extracted;
   ii. Age and condition of existing partials, or a statement identifying the prosthesis as an initial placement; and,
   iii. Radiographs.

6-003.02F12 Tissue Conditioning: Covered one time during the first 180 days following placement of a prosthetic appliance. Following the initial 180 days, necessary tissue conditioning may be covered two times per prosthesis every 365 days, with documentation in the dental record.

6-003.02G Oral and Maxillofacial Surgery

6-003.02G1 Extractions Routine and Surgical: Medicaid covers necessary extraction of teeth when there is documented medical need for the extraction. The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care.

6-003.02G1a Documentation Requirements: Document the medical reason for extractions in the dental chart.

6-003.02G2 Tooth Reimplantation and/or Stabilization of an Accidentally Avulsed or Displaced Tooth and/or Alveolus: The Medicaid fee includes splinting and/or stabilization.
6-003.02G3 Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons: The Medicaid fee includes the orthodontic attachment.

6-003.02G4 Biopsy of Oral Tissue (Hard or Soft): The Medicaid fee is for the professional component only. The lab must bill the specimen charge.

6-003.02G5 Alveoloplasty: The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary. It is not a separate billable procedure.

6-003.02G5a Alveoloplasty In Conjunction With Extractions: Covered per quadrant as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.

6-003.02G6 Excisions: See 471 NAC 6-004.01B3

6-003.02G7 Occlusal Orthotic Device, By Report: The fee includes any necessary adjustments. For treatment of bruxism or for minor occlusal problems, see Occlusal Guard on 471 NAC 6-003.02H8.

6-003.02G7a Documentation Requirements: Document the type of appliance made, and medical necessity.

6-003.02H Orthodontics: Medicaid covers prior authorized (see 471 NAC 6-003.01B(vii)) orthodontic treatment for clients who are age 20 or younger, and have a handicapping malocclusion.

6-003.02H1 Coverage Criteria for Diagnostic Models and Radiographs: Diagnostic records are not covered by Medicaid unless the case will qualify for Medicaid coverage as outlined in this (471 NAC 6-003.02G) section. Diagnostic records for minor malocclusions are not covered by Medicaid.

For auditing purposes, Medicaid may request end of treatment diagnostic models and x-rays. Payment for the end of treatment records will be included in the dollar amount prior authorized (see 471 NAC 6-004.02B4). The end of treatment records shall be submitted to the Department for review by the dental consultant.

6-003.02H2 Forms: Appendix 471-000-406 contains an orthodontic Handicapping Labiolingual Deviation (HLD) form that shall be used to pre-screen orthodontic cases. This appendix also includes request forms that shall also be used to submit prior authorization requests for orthodontic treatment.

6-003.02H3 Orthodontic Treatment: To be eligible for orthodontic treatment, a client must be age 20 or younger when treatment is authorized, have a handicapping malocclusion (see 471 NAC 6-001), which includes one or more of the following five documented conditions:
i. Accident causing a severe malocclusion;
ii. Injury causing a severe malocclusion;
iii. Condition that was present at birth causing a severe malocclusion;
iv. Medical condition causing a severe malocclusion; and
v. Facial skeletal condition causing a severe malocclusion.

When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. The pre-treatment request must contain documentation of the client’s medical condition, or surgical correction.

Treatment is prior authorized and paid on a single procedure code. The authorized code will be on the MC-9D prior authorization form (Appendix 471-000-201) or the ASC X 12N 278. In order for Medicaid clients to receive timely treatment, the request for approval shall constitute the provider’s acceptance of the Medicaid fee, and a commitment to complete care.

6-003.02H3a Documentation Requirements: The following documentation must be submitted with the prior authorization request.
   i. A pre-treatment request form that outlines treatment to be completed and the Handicapping Labiolingual Deviation (HLD) Index Form in appendix 471-000-406;
   ii. Diagnostic records:
       1) Diagnostic casts and/or Oral/facial photographic images;
       2) Full mouth radiographs and/or Panoramic x-ray; and
       3) Cephalometric x-ray.
   iii. A narrative description of the diagnosis, and prognosis; and,
   iv. On surgical cases include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

6-003.02H4 Interceptive Orthodontic Treatment of Transitional Dentition: Covered if cost effective to lessen the severity of a malformation such that extensive treatment is not required.

6-003.02H5 Removable and Fixed Appliance Therapy (thumb sucking and tongue thrust): Covered for clients age 20 and younger, includes adjustments.

6-003.02H6 Repair of Orthodontic Appliances: Covered for clients age 20 and younger.

6-003.02H6a Documentation Requirements: Include a description of the repair on the dental claim, and in the dental chart.

6-003.02H7 Orthodontic Retainers (Replacement): Covered for clients age 20 and younger if the client is compliant with wearing the appliance.
6-003.02H8 Repair of Bracket and Standard Fixed Orthodontic Appliances: Covered for clients age 20 and younger, when repairs exceed routine repairs associated with orthodontic treatment.

6-003.02I Adjunctive General Services

6-003.02I1 Palliative Treatment: Palliative treatment is covered once per date of service per location. Examples of palliative treatment are treatment of soft tissue infection; smoothing a fractured tooth. Exception: Palliative treatment on a specific tooth is not covered if definitive treatment (e.g. restorative or endodontic treatment) was provided on the same tooth for the same date of service.

6-003.02I1a Documentation Requirements: Document the palliative treatment provided on or in the dental claim, and in the dental chart.

6-003.02I2 General Anesthesia: General anesthesia administered in the provider's office is covered when it is medically necessary to treat the client. Administration of general anesthesia must be performed in full compliance with Neb. Rev. Stat. §38-101 to §38-1140.

6-003.02I2a Documentation Requirements: Document in the dental chart the medical necessity for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I3 Analgesia, Anxiolysis, Inhalation of Nitrous Oxide: Covered when medically necessary to treat the client.

6-003.02I4 Intravenous Sedation/Analgesia: Intravenous sedation/analgesia administered in the provider’s office or location is covered when it is medically necessary to treat the client.

6-003.02I4a Documentation Requirements: Document in the dental chart the medical need for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I5 Non-Intravenous Conscious Sedation: Non-intravenous conscious sedation administered in the provider’s office is covered when it is medically necessary to treat the client. The use of oral medications require monitoring.

6-003.02I5a Documentation Requirements: Document in the dental chart the medical need for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.
6-003.0216 House Call, (Nursing Facility Call), Hospital Call, Ambulatory Surgical Center (ASC) Call: Covered one per day per facility regardless of the number of patients seen.

6-003.0216a Documentation Requirements: Document on or in the dental claim the name of the facility, or home address where treatment was provided.

6-003.0217 Office Visit – After Regularly Scheduled Hours: Covered in addition to an exam and treatment provided, when treatment is provided after normal office hours.

6-003.0218 Occlusal Guard: Covered once every 1095 days to minimize the effects of bruxism and other occlusal factors. Occlusal guards are removable appliances. Athletic guards are not covered.

6-003.0218a Documentation Requirements: Document the medical necessity for the occlusal guard in the dental chart. Documentation should support evidence of significant loss of tooth enamel or tooth chipping, or the medical documentation supports headaches and/or jaw pain.

6-003.03 Non-Covered Services: Medicaid does not cover any service that is:
1. cosmetic;
2. more costly than another, equally effective available service;
3. not within the coverage criteria of these regulations;
4. determined not medically necessary by the Department; or
5. experimental, investigational, or non-FDA approved.

6-004 Billing and Payment for Dental Services

6-004.01 Billing

6-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 6, the billing requirements in 471 NAC Chapter 6 shall govern.

6-004.01B Specific Billing Requirements

6-004.01B1 Billing Instructions: The Provider shall bill Medicaid using the procedure codes outlined in the Nebraska Medicaid Dental Fee Schedule (Appendix 471-000-506), and in accordance with the billing instruction included in Appendix 471-000-88. The fees listed on the dental claim must be the dentist’s usual and customary charge for each procedure code.

6-004.02 Payment

6-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471
NAC Chapter 3. In the event that individual payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 6, the individual payment regulations in 471 NAC Chapter 6 shall govern.

6-004.02B Specific Payment Requirements

6-004.02B1 Reimbursement: Medicaid pays for covered dental services at the lower of:
1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule (Appendix 471-000-506) in effect for that date of service.

6-004.02B2 Restorative Services Rates: Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.

6-004.02B3 Payment for Interceptive and Comprehensive Orthodontic Treatment: Payment for authorized orthodontic treatment is made upon approval of the treatment plan and submittal of a dental claim.

6-004.02B3a Transfer of Interceptive and Comprehensive Orthodontic Cases: If the client transfers to another dentist, the dentist who obtained the original authorization and initiated orthodontic treatment, shall refund to Medicaid the portion of the amount paid by Medicaid that applies to the treatment not completed. The transfer request must be submitted and reviewed by the Dental Consultant to determine the amount to be refunded. Transfers are only allowed under hardship circumstances; i.e. Travel distances.

6-004.02B3b Interceptive and Comprehensive Orthodontic Treatment Not Completed: If prior authorized orthodontic treatment is not completed, the dentist who obtained the original authorization and initiated the treatment shall refund to Medicaid the portion of the amount paid by Medicaid that applies to the treatment not completed. The request to discontinue treatment must be submitted and reviewed by the Dental Consultant to determine the amount to be refunded.

6-004.02B4 Audit Records: Medicaid may request end of treatment diagnostic models and x-rays in accordance with 471 NAC 6-003.02G1. Payment for the end of treatment records is included in the dollar amount prior authorized.

6-004.02B5 Supplemental Payments: See Appendix 471-000-506.
CHAPTER 7-000 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND MEDICAL SUPPLIES (DMEPOS)

7-001 Standards for Participation: To participate in Medicaid, providers shall be enrolled as a DMEPOS Provider or a Facility Provider. DMEPOS and facility providers participating in Medicaid shall meet any applicable state and federal laws governing the provision of their services.

Medicaid does not generally enroll hospitals, physicians, and other licensed practitioners as providers of durable medical equipment, medical supplies, orthotics and prosthetics.

Medicaid enrolls as providers of DMEPOS only those providers who are involved in the direct provision of services or items to the client.

7-002 Covered Services: Medicaid covers medically necessary DMEPOS which meet program guidelines when prescribed by a physician (M.D., D.O., D.P.M.).

7-002.01 Services Provided for Clients Enrolled in Nebraska Medicaid Managed Care: Certain Medicaid clients are required to participate in Managed Care. See 471-000-122 for a listing of the plans.

7-002.01A Nebraska Medicaid Managed Care Plans: Plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in a Managed Care plan. Services provided to clients enrolled in a Managed Care plan are not billed to Medicaid. The provider shall provide services only under arrangement with the Managed Care plan.

7-003 Non-Covered Services: Medicaid does not cover items which primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, and new equipment of unproven value, and equipment of questionable current usefulness or therapeutic value.

This Chapter's coverage index, although not intended to be all inclusive, specifies items which are generally not covered by Medicaid (see 471 NAC 7-013).
7-004 Definitions: Medicaid uses the following definitions -

**Bed-confined:** The client’s condition is so severe that the client is essentially confined to bed, although not necessarily 100 percent of the time.

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

**Custom fabricated:** Made for a specific client from his/her individualized measurements and/or pattern.

**Custom fitted:** Substantial adjustments are made to a prefabricated item by a specially trained professional to meet the needs and/or unique shape of an individual client. Casting or molding techniques are not used in fabrication.

**Durable Medical Equipment:** Equipment which -

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client’s home.

**Facility:** In this Chapter refers to any nursing facility (471 NAC 12) or ICF/DD (471 NAC 31) currently enrolled as Medicaid providers.

**Homebound:** The client’s condition is such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration or are attributable to the need to receive medical treatment.

**ICF/DD:** Intermediate Care Facility for Individuals with Developmental Disabilities and Persons with Related Conditions (formerly known as ICF/MR’s). This is inclusive of ICF/IID services defined in CFR 440.150.

**Medical Supplies:** Expendable or specified reusable supplies required for care of a medical condition in the client’s home. This does not include personal care items (e.g., deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc.) or oral or injectable over-the-counter drugs and medications.

**Molded to patient:** Direct molding on the involved portion of a client’s body. This material is ultimately used in the device being fabricated.

**Molded to patient model:** A process in which an impression is made of the specified body part. This impression is used to make a positive model (usually plaster) of the body part. The orthosis is then custom fabricated and/or fitted using this model.

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

**Prosthetics:** Devices to replace a missing body part.
7-005 Services for Clients Residing in Nursing Facilities and Intermediate Care Facilities for Individuals with Developmental Disabilities and Persons with Related Conditions (ICF/DD’s): Medicaid reimburses DMEPOS providers for only the following items for clients residing in nursing facilities and ICF/DD’s, if the client’s condition meets the coverage criteria for the item as outlined in 471 NAC 7-013. The DMEPOS provider shall follow any prior authorization requirements outlined in this chapter.

1. Orthoses (lower and upper limb, foot, and spinal) as defined in this Chapter; and
2. Prostheses (breast, eye, lower and upper limb) as defined in this Chapter.

Air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to the nursing facility or ICF/DD according to the maximum allowable rate on the durable medical equipment and supplies fee schedule found at 471-000-507.

All other items necessary for the care of clients residing in nursing facilities or ICF/DD’s are included in payments to the facility and cannot be billed directly by a DMEPOS provider to Medicaid.

At the time of the client’s transfer or discharge, the following items specifically purchased for and used by the client shall be transferred with the client:

1. Any non-standard wheelchair and wheelchair accessories, options, and components, including power operated vehicles;
2. Augmentative communication devices with related equipment and software;
3. Supports (e.g. trusses and compression stockings with related components); and
4. Custom fitted and/or custom fabricated items.

7-006 Services Provided to Hospital Patients: Hospital patients are defined as registered inpatients and outpatients of a hospital, including a rehabilitation hospital, for the primary purpose of receiving medical services. DMEPOS (including fittings) provided to hospital patients may be provided directly by the hospital or under arrangements with a non-hospital supplier/provider. Payment is made to the hospital according to the Medicaid reimbursement methodology for hospital services. Payment is not made separately to the DMEPOS provider. EXCEPTION: In the event a customized wheelchair for primary use in OTHER than the hospital setting is needed for training purposes while the client is a hospital inpatient, the non-hospital supplier/provider may deliver the wheelchair to the client during the inpatient stay and bill Medicaid. This exception does not apply to other items provided for use in the hospital setting.
7-007 Documentation of Medical Necessity: The provider shall obtain written documentation from the prescribing physician which justifies the medical necessity for durable medical equipment, medical supplies, orthotics and prosthetics and related services provided. The original documentation of medical necessity must be kept on file by the provider. The documentation must -

1. Be signed by the physician's own hand (stamps or other substitutes may not be used) and dated, using the date the documentation is signed;
2. Specify the start date of the order if the item is provided before the date the documentation is signed;
3. Include the physician's name, address and telephone number;
4. Include the diagnosis and/or condition necessitating the item(s) and an estimate of the total length of time the item will be needed (in months or years). The estimated total length of time the item will be needed must be completed by the physician or physician's office staff;
5. Be sufficiently detailed, including all options or additional features which will be separately billed or will require an upgraded procedure code;
6. Describe the ordered item(s) using either a narrative description or a brand name/model number, including all options or additional features (this may be completed by someone other than the physician, but the physician must review the order and sign and date it to indicate agreement);
7. For supplies provided on a periodic basis, include appropriate information on the quantity used, frequency of change and duration of need (PRN or "as needed" may not be used); and
8. Include information substantiating that all Medicaid coverage criteria for the item(s) are met.

7-007.01 Medicaid Certification of Medical Necessity Forms: Use of the following Medicaid Certification of Medical Necessity (CMN) forms is required. Form examples and completion instructions are included in the Medicaid Provider Handbook -

Form MS-78, "Augmentative Communication Device Selection Report"
Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report"
Form MS-80, "Air Fluidized and Low Air Loss Bed Certification of Medical Necessity"

7-007.02 Medicare Certification of Medical Necessity Forms: Use of Medicare CMN forms, when a specific Medicaid CMN form does not exist, is strongly encouraged. When using Medicare CMN forms, Medicare completion instructions apply. Use of the following Medicare CMN form is required -

Medicare "Attending Physician's Certificate of Medical Necessity for Home Oxygen" form (latest revised edition)
7-007.03 Recertification of Medical Necessity: Documentation of medical necessity must be updated annually or when the physician's estimated quantity, frequency or duration of the client's need has expired, whichever occurs first, unless otherwise specified in this Chapter's coverage index.

7-007.04 Second Opinion: Medicaid may request a second opinion to document medical necessity.

7-008 Prior Authorization

7-008.01 Prior Authorization Requirements: Prior authorization is required for payment of rental and purchase of the items listed below. Note: Prior authorization by Medicaid is not required for payment of Medicare or other primary insurance coinsurance and deductible. Prior authorizations are not required for clients residing in a NF or ICF/DD.

1. Augmentative communication devices with related equipment and software;
2. Spinal orthosis seating systems and back modules incorporated in or attached to a wheelchair base;
3. Transcutaneous electrical nerve stimulators (TENS);
4. Ultraviolet cabinets;
5. Non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles;
6. Whirlpools;
7. NOC (not otherwise classified) durable medical equipment - ONLY when the purchase price of the item exceeds $500; and
8. Any item for a client whose condition does not meet the Medicaid coverage criteria for the item.
7-008.02 Requests for Prior Authorization: The provider shall submit requests for Medicaid prior authorization electronically 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) or by completing and submitting a clear reproduction of Form MS-77 according to the form instructions.

A full-sized copy of Form MS-77 is included in the Medicaid Provider Handbook (see 471-000-206 for an example of the form and completion instructions).

The provider shall submit the documentation of medical necessity as outlined in 471 NAC 7-007 with each prior authorization request.

The Medicaid Division shall review the prior authorization request and documentation. The Department will notify the provider of the coverage decision on Form MS-77, “Prior Authorization Request”, or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or if additional information is needed, the specific information will be requested.

7-008.03 Prior Authorization Limitations: Approved prior authorizations are valid only if -

1. The client is Medicaid-eligible at the time services are provided. It is the responsibility of the provider to verify the client's Medicaid eligibility for the date of services;
2. The client's condition meets the Medicaid coverage criteria for the item at the time of purchase or for the duration of the rental period;
3. For rentals, the item is used appropriately by the client for the duration of the rental period;
4. The client's living arrangement does not change. Movement to a nursing facility, ICF-DD or hospital may invalidate an approved prior authorization;
5. The client is not enrolled in a Nebraska Medicaid Managed Care Plan at the time the service is rendered; and
6. All other Medicaid policies are followed.

7-009 (Reserved)
7-010 General Coverage Requirements and Limitations:

7-010.01 Coverage Criteria: Criteria for Medicaid coverage of some DMEPOS is outlined in this Chapter's coverage index (see 471 NAC 7-013). Items not specifically listed may not be covered by Medicaid. In order to be covered by Medicaid, the client's condition must meet the coverage criteria for the specific item. Documentation which substantiates that the client's condition meets the coverage criteria must be on file with the provider (see 471 NAC 7-007 for documentation of medical necessity requirements).

Exception: Some items of equipment may be covered under certain conditions even though they do not meet the exact definition of durable medical equipment. These items may be approved only by the appropriate staff of the Medicaid Division. To be covered, the equipment must prevent frequent hospitalizations or institutionalization, or serve a therapeutic purpose in an individual case. Use of these items must be included in the physician's course of treatment and be supervised by him/her.

7-010.02 (Reserved)

7-010.03 Maximum Quantity for Supplies: The maximum allowable quantity of supplies that may be dispensed is limited to a three (3) month supply, unless otherwise specified in this Chapter's coverage index (see 471 NAC 7-013). Providers may not bill for supplies dispensed in advance and may only bill at the end of the three (3) month period, or at the end of each month.

7-010.04 Multiple or Duplicate Items: Medicaid does not cover purchase, rental or repair of multiple or duplicate durable medical equipment, orthotics or prosthetics used for the same or similar purposes (e.g., power and manual wheelchairs, two nebulizers for use at different locations, etc.) Medicaid does not cover back-up equipment. Back-up equipment may be supplied by the provider, but the provider may not bill Medicaid.

7-010.05 Replacement: Replacement of medically necessary, Medicaid-covered DMEPOS owned by the client is covered if needed due to change in the client's medical condition, wear, loss, irreparable damage, except for malicious damage, culpable neglect or wrongful disposition. Replacement required due to malicious damage, or culpable neglect, or wrongful disposition should be referred to the Medicaid Division for review.
7-010.06 Repair: Medicaid covers repair required for the effective use of durable medical equipment, orthotics, and prosthetics when -

1. The item is covered by Medicaid;
2. The client's condition meets the coverage criteria for the item; and
3. The item is owned by the client.

The cost of the repair may not exceed 80% of the Medicaid allowable purchase price for the item. Payment for labor charges is covered only in conjunction with repair. All manufacturer and provider warranties must be pursued. Repairs required due to malicious damage or culpable neglect should be referred to the Medicaid Division for review.

Medicaid covers rental of covered durable medical equipment for a maximum of three (3) months during which time the client-owned equipment is being repaired. If at any time the provider's usual business practice is to provide loaner equipment at no charge, the provider shall not bill Medicaid for rental during that period.

When billing for repair of durable medical equipment, the provider shall indicate if the item repaired is client owned.

7-010.07 Orthoses and Prostheses: Medicaid payment for orthoses and prostheses includes -

1. Evaluation;
2. Fitting;
3. Cost of parts and labor;
4. Repairs due to normal wear and tear for a minimum of 90 days from the date dispensed; and
5. Adjustments made when fitting and for a minimum of 90 days from the date dispensed when the adjustments are NOT necessitated by changes in the client's medical condition (e.g., residual limb) or the client's functional abilities.

Orthotic/prosthetic evaluations are reimbursable only when no device, orthosis, prosthesis, part, repair or adjustment is provided.

7-010.08 Supplies/Accessories for Durable Medical Equipment: Supplies and accessories required for the proper functioning and effective use of durable medical equipment are covered when -

1. The equipment is covered by Medicaid;
2. The client's condition meets the coverage criteria for the equipment; and
3. The equipment is owned by the client.

Supplies and accessories for rented durable medical equipment are generally included in the Medicaid rental payment, unless specifically allowed as outlined in this Chapter's coverage index.
7-010.09 Rental: The following requirements apply to items provided on a rental basis. If the provider is unable to meet these requirements, the Department may select another provider.

7-010.09A Rental/Purchase Decision: Items with a purchase price under $150 may be purchased rather than rented, unless the physician’s estimated duration of need is less than 6 months. Items with a purchase price of $150 or greater must be rented, unless the physician’s estimated duration of need is 12 months or greater.

7-010.09B Rental Option to Purchase: All rentals, except those listed below, must carry an option to purchase the item. THE PROVIDER SHALL CEASE ALL BILLING FOR RENTAL when rental payments reach the provider’s purchase price or after 12 monthly rental payments, whichever occurs first. Upon conversion to purchase, the item becomes the property of the client.

When converting a rental item to purchase before 12 months of rental, all rental paid or authorized shall be applied toward the Medicaid allowable purchase price. When converting from rental to purchase before 12 months of rental, the provider shall use the appropriate procedure code modifier and list the initial rental date and purchase on or with the claim.

The following items are exempt from the rental/purchase option, remain the property of the provider, and may be rented on a monthly basis -

1. Oxygen delivery equipment; and
2. Ventilators.

The following items are exempt from the rental/purchase option. After 12 monthly rental payments, the item will be paid on a monthly "maintenance" basis and will remain the property of the provider. Providers shall use the appropriate procedure code modifier when billing for monthly "maintenance" -

1. Air fluidized bed units;
2. Apnea monitors;
3. Compressors (air power sources for equipment which is not self-contained or cylinder driven);
4. Low air loss bed units; and
5. Oximeters.

Other items may be exempt from the rental/purchase option if approved by the Medicaid Division.
7-010.09C Rental Payment: Payment for rental includes:

1. All necessary repair and replacement parts; and
2. All accessories and supplies necessary for the effective use of the equipment, unless specifically allowed as outlined in the coverage criteria for the item.

7-010.09D Rental Billing Procedures:

1. Providers shall bill for rental only while the item continues to be medically necessary and appropriately used by the client;
2. Rental items not used by the client for more than a one month period (e.g., during inpatient hospitalization) may not be billed to Medicaid. The provider is responsible for determining whether the item continues to be used by the client; and
3. The provider shall bill rental on a monthly basis unless the item is used for less than a one-month period. When billing for monthly rental, the unit of service "1" indicates a one-month rental period. The provider shall use the appropriate procedure code modifier when billing for monthly rental. The beginning rental date for each month shall be the day of the month on which the item was initially provided. A monthly rental period is not necessarily a calendar month or a standard number of days (e.g., 28, 30, 31). Examples of monthly rental periods are:
   - January 5 - February 4
   - March 20 - April 19
   - June 15 - July 14

When rental equipment is needed at any time by the client for less than a one-month rental period, the rental is paid on a daily pro-rated basis. The provider shall use the appropriate procedure code modifier when billing for daily rental. The unit of service must reflect the number of days the item was actually used.

4. When billing for rental items, the provider shall indicate both "from" and "to" dates of service and the initial rental date.

7-010.09E Rental Delivery and Setup: If the client no longer requires rental equipment during the first month rental period and the rental item required delivery and set-up (e.g., oxygen delivery equipment, hospital bed, etc.), the provider may bill for "equipment set-up" in addition to the daily pro-rated rental fee for the days the equipment was actually used. Delivery and set-up charges may not be billed for client instruction on use of equipment or for equipment that is generally covered or customarily provided for a period of less than one month (e.g., home phototherapy services, CPM devices, etc.).

7-010.09F Loss/Damage of Rental Items: The Department is not responsible for lost, stolen, or damaged rental items.
7-010.10 Used Equipment: Used equipment is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator). The provider must assure that used equipment meets the same standard of quality as new equipment and must provide comparable warranty, servicing and return policies available with new equipment.

When billing for used equipment, the provider shall use the appropriate procedure code modifier.

7-010.11 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under Medicaid but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division.

7-011 Payment Methodology: Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "RNE" - rate not established - in the fee schedule). A copy of the purchase invoice showing the provider's actual cost for an item may be requested and used for pricing.

7-011.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers may access information on fee schedules and changes in fee schedules on the DHHS Website under Provider Information page links.

7-011.02 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471 NAC 3-004.
7-012 Billing Requirements: Providers shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

Any item billed to Medicaid must actually be dispensed or directly supplied by the provider that bills for the item. This does not preclude a provider from contracting with billing agents.

The provider or the provider’s authorized agent shall submit the provider’s usual and customary charge for each procedure code listed on the claim. Any discount offered to the public must be reflected in the provider’s submitted charge, except discounts for cash payment at the time of sale.

7-012.01 Procedure Codes and Modifiers: The provider shall bill the Department using the appropriate HCPCS procedure codes and modifiers.

HCPCS procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-507).
7-013 Coverage Index

**Note**: HCPCS procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-507).

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIR CLEANERS/PURIFIERS ......</td>
<td>Not covered-environmental control equipment; not primarily medical in nature.</td>
</tr>
<tr>
<td>AIR CONDITIONERS ...............</td>
<td>Not covered-environmental control equipment; not primarily medical in nature.</td>
</tr>
<tr>
<td>AIR FLUIDIZED and LOW AIR LOSS BED UNITS ...............</td>
<td>Covered on a rental basis for -</td>
</tr>
</tbody>
</table>
| 1. A maximum period of 20 weeks for active healing and treatment of stage III (full thickness tissue loss) or stage IV (deep tissue destruction) decubiti located on the trunk or pelvis, while progressive, consistent wound healing occurs; or 2. A maximum period of eight weeks from the date of surgery for post-operative healing of major skin grafts or myocutaneous flaps on the trunk or pelvis. The client must be placed on the bed unit immediately after the surgical procedure. (**Note**: The supplier does not bill Medicaid for services provided while the client is a hospital patient (see 471 NAC 7-006).)

**Note**: Medicaid does not cover air fluidized beds for prevention of decubiti or pain control.

**Note**: Air powered mattress overlays or mattress replacements are not covered.

The following conditions must be met and documented prior to placement of an air fluidized or low air loss bed unit -

1. Comprehensive client assessment and evaluation by the attending physician has occurred;
2. Conservative treatment has been tried without success;
3. Caregiver training on use of the bed by a registered nurse employed by the provider has occurred; and
4. Initial dietary consult has occurred, which includes recommended caloric intake and serum albumin level at or near the time of placement.
The following conditions must be met and documented during use of air fluidized or low air loss bed units -

1. A trained adult caregiver is available to assist the client with activities of daily living, fluid balance, skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments and management and support of the bed;
2. Wound healing must begin within 14 days of placement on the bed unit. If progressive, consistent wound healing ceases during use of the bed, care plan changes and wound healing must be reestablished within 14 days;
3. The client must remain on the bed unit at all times except for a maximum of 1 hour per day and when receiving medical treatment (e.g., physician visits, whirlpool treatment, etc.);
4. On-site client evaluation and wound care consultation by a registered nurse employed by the provider occurs weekly;
5. Changes in the client’s status, treatment, diet, etc., is monitored and documented; and
6. A written plan of care must be established within 4 weeks of placement of bed unit. The plan of care must address skin care, pressure reducing devices and protocol, and dietary needs after use of bed unit has been discontinued.

Payment: Medicaid rental payment includes -

1. Air fluidized or low air loss bed unit and all accessories and services necessary for proper functioning and effective use of the bed;
2. Weekly on-site client evaluation and wound care consultation by a registered nurse employed by the provider, with 24 hour per day availability; and
3. Complete caregiver training on use of equipment, wound care and prevention.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The provider must have documentation on file that substantiates that all requirements for coverage are met. Form MS-80 "Air Fluidized and Low Air Loss Bed Certification of Medical Necessity" must be completed on a monthly basis by a registered nurse employed by the provider and signed by the ordering physician and kept on file with the provider. (See 471-000-209 for form and completion instructions.)
APNEA MONITORS .......................... Covered on a rental basis for infants (birth through completion of one year of age) that meet one of the following criteria -

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

2. Symptomatic preterm infants;

3. Siblings of one or more SIDS victims; or

4. Infants with certain diseases or conditions, such as central hyperventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants with substance-abusing mothers, or infants with less severe ALTE's.

Criteria for discontinuing apnea monitoring must be based on the infant’s clinical condition. A monitor may be discontinued when ALTE infants have had two- three months free of significant alarms or apnea requiring vigorous stimulation or resuscitation. Evaluating the infant’s ability to tolerate stress (e.g., immunizations, illness) during this time is advisable.

Pneumocardiograms are covered for diagnostic/evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation. This service must be billed by the physician performing the service.
Note: Medicaid does not cover monitors that do not use rechargeable batteries.

The following conditions must be met prior to initiation of home apnea monitoring -

1. History and physical assessment by the infant's attending physician; and
2. Parent/caregiver have successfully completed training on use of the equipment and any other physician recommended training (e.g., infant resuscitation and stimulation).

Payment: Medicaid rental payment includes complete parent/caregiver training on use of the equipment and record keeping. Medicaid does not make separate payment for remote alarms. When provided, payment for a remote alarm is included in the monitor rental payment.

Supplies/Accessories: Apnea monitor supplies are covered for use with rented and client-owned apnea monitors. For rented apnea monitors, the apnea monitor supplies must be billed on the same claim as the apnea monitor rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The provider must have documentation on file that substantiates that all conditions for coverage are met. Apnea monitor rental exceeding two months requires a physician's narrative report of client progress to be kept on file with the provider. A new progress report is required every two months. The report must include -

1. The number of apnea episodes during the previous two-month period of use;
2. Tests and results of tests performed during the previous two-month period of use;
3. Estimated additional length of time the monitor will be needed; and
4. Any additional pertinent information the physician may wish to provide.
BATH and TOILET AIDS............. The following bath and toilet aids are covered for clients with severe conditions which justify use of the item: bath/toilet rails, raised toilet seats, tub stools and benches, transfer tub benches and attachments, and bath support chairs.

Bathtub patient lifts and rehabilitation shower chairs are covered for clients with severe conditions who, without use of the equipment, would be unable to bathe or shower. The client must be unable to use a stationary tub stool or bench, rails and/or similar equipment.

Note: Bed baths and shower attachments (e.g., hand-held shower attachments, faucet adapters, etc.) are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

BED BATHS.......................... Not covered-hygienic equipment; not primarily medical in nature.

BED LIFTERS.......................... Not covered-not primarily medical in nature.

BED SIDE RAILS..................... Covered for clients who are at risk for injury due to one of the following conditions -

1. Disorientation;
2. Vertigo; or
3. A neurological disorder resulting in convulsive seizures.

Bed side rails are also covered when an integral part of, or an accessory to, a hospital bed.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also HOSPITAL BED ACCESSORIES.)

BED TABLES, ANY TYPE.......... Not covered-convenience item; not primarily medical in nature.

BED WEDGES.......................... Covered for clients that require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration. Standard bed pillows must have been tried and failed.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

BEDBOARDS......................... Not covered-not primarily medical in nature.
BEDPANS and URINALS .......... Covered for clients who are bed-confined.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

BEDS, HOSPITAL ................. See HOSPITAL BEDS.

BEDS, LOUNGE (MANUAL OR POWER)................................. Not covered-not a hospital bed; comfort or convenience item; not primarily medical in nature.

BEDS, OSCILLATING .............. Not covered-institutional equipment; inappropriate for home use.

BIOFEEDBACK DEVICES .......... See ELECTROMYOGRAPHY (EMG) BIOFEEDBACK DEVICES.

BLOOD GLUCOSE MONITORS............... Covered for clients that meet all of the following conditions -

1. The client is diabetic (includes non-insulin treated diabetes and gestational diabetes);
2. The client's physician states that the client is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the client may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the client to assure that the intended effect is achieved. This is permissible if this information is properly documented by the client's physician; and
3. The device is designed for home rather than clinical use.

Blood glucose monitors with such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable clients with visual impairments to use the equipment without assistance are covered when the following conditions are met -

1. The client and device meet the three conditions listed above for coverage of standard blood glucose monitors; and
2. The client's physician certifies that the client has a visual impairment severe enough to require use of this special monitoring system.
Supplies/Accessories: Supplies necessary for effective use and proper functioning of a blood glucose monitor are covered for use with rented and client-owned monitors for clients whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is strongly encouraged.

BLOOD PRESSURE MONITORS

Covered for clients with hypertension whose condition must be self-monitored at home. An electronic blood pressure monitor is covered only if the client is unable to use a standard cuff and stethoscope due to conditions such as poor eyesight or hearing, arthritis, or other physical disability.

Note: Blood pressure monitors required for renal dialysis are payable ONLY to approved renal dialysis facilities. (See DIALYSIS EQUIPMENT AND SUPPLIES.)

Supplies/Accessories: Payment for purchase and rental of a blood pressure monitor includes all accessories necessary for proper functioning and effective use of the monitor. Accessories are payable only as replacement for use with client-owned monitors for clients whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The documentation must specify the cuff size, that the physician will be monitoring its use in connection with the client's continuing course of treatment, and that the client or caregiver will be instructed in use of the equipment by the physician, physician's office staff or other qualified health professional.

BONE GROWTH STIMULATORS

See OSTEOGENESIS STIMULATORS.

BRAILLE TEACHING TEXTS

Not covered—education equipment; not primarily medical in nature.

BREAST PROSTHESES

Covered for clients who have had a mastectomy.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
BREAST PUMPS..................... Covered for clients who are breast feeding if one of the conditions listed below for short term or long term rental are met. Hospital grade breast pumps are covered only on a rental basis.

SHORT TERM RENTAL (up to 2 months)
1. Infant/neonate with abnormal weight loss
2. Hyperbilirubinemia
3. Inadequate milk supply
4. Mastitis
5. Acutely ill infant
6. Infant food allergy (to maintain milk supply for a limited period until off the offending foods)
7. Medical condition of mother that precludes feeding infant at breast (examples include, but not limited to: mom on radioactive compound or other medication short term)
8. Maternal post-partum complications (examples but not limited to: excessive fluids during delivery, maternal blood loss, D&C)

LONG TERM RENTAL (up to 6 months, with one additional 6 month period if medically necessary)
1. Congenital abnormality of the infant (examples, but not limited to: cleft lip/palate, Down syndrome, other syndrome with poor suck/swallow, abnormal anatomy, congenital heart disease)
2. Neurologic abnormality of the infant (examples, but not limited to: low tone, poor suck/swallow reflex)
3. Prematurity (less than 37 weeks gestation)
4. Latch difficulties

Supplies/Accessories: During rental of a breast pump, supplies and accessories necessary for proper functioning and effective use of the pump are included in the rental allowance. For the purchase of a pump, the allowance includes supplies and accessories needed for one month. Accessories and supplies are payable only as a replacement for use with client-owned pumps for clients whose condition meets the criteria for coverage of the pump.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
CANES and CRUTCHES ............ Covered for clients with conditions that impair ambulation.

Note: A white cane for use by a blind person is considered an identifying and self-help device rather than an item which makes a meaningful contribution to the treatment of an illness or injury and is therefore not covered.

Supplies/Accessories: Payment for purchase and rental of canes and crutches includes all accessories necessary for proper functioning and effective use of the item. Accessories such as tips, handgrips, etc., are payable only as replacement for use with client-owned canes or crutches for clients whose condition meets the criteria for coverage of the item.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

CAR SEATS.......................... Positioning seats approved for use in vehicles are covered for clients age 20 and younger with physical disabilities when required for positioning during transportation when standard seat belts or infant car seats are not appropriate.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

CARAFES ............................. Not covered—convenience item; not primarily medical in nature.

COMMODES............................ Covered for clients who are confined to bed or room or confined to home in which there are no bathroom facilities on that floor or bathroom facilities are inaccessible.

A commode chair with detachable arms is covered only if medically necessary, such as for obesity or paraplegia.

Supplies/Accessories: Payment for purchase and rental of a commode includes all accessories necessary for proper functioning and effective use of the commode. Accessories such as a commode pail or pan are payable only as replacement for use with client-owned commodes whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
COMMUNICATION DEVICES, AUGMENTATIVE

Covered for clients who are unable to use natural oral speech as a primary means of communication. The specific device requested must be appropriate for use by the client and the client must demonstrate the abilities or potential abilities to use the device selected. Client/family/environment must support the use of the device.

Coverage is limited to portable devices needed to supplement, aid or serve as an alternative to natural speech for clients with severe expressive communication disorders. Non-portable devices may be covered only if required for visual enhancement or physical access needs that cannot be accommodated by a portable device.

An evaluation of the client's communication needs by a qualified professional speech pathologist is required. A background and experience in augmentative communication is recommended.

A qualified professional speech pathologist must -

1. Have been granted a certificate of clinical competence from the American Speech and Hearing Association or have completed the equivalent educational requirements and work experience needed for the certificate or have completed the academic program and is acquiring supervised work experience to qualify for the certificate; and

2. If practicing in Nebraska, be licensed by the Nebraska Department of Health and Human Services or be certified by the Nebraska Department of Education; or

3. If practicing outside Nebraska, meet that state's requirements for participation in the Medicaid Program.

The evaluation must address the client's medical diagnosis, speech-language diagnosis, physical status, communication abilities, vision and hearing acuity, cognitive, neuromotor, language and other skills or potential required for use of the specific device selected. The specific device recommended, along with all accessories required for use of the device must be identified and the selection justified.

A trial period with the device selected may be required. A maximum of three months rental may be approved for rental of devices not subsequently purchased. (See 471 NAC 7-010.08 for rental requirements.)
When an augmentative communication device with related equipment and software is no longer needed or when a replacement device is requested, it is strongly encouraged that augmentative communication devices with related equipment and software purchased with Medicaid funds be donated to a regional or facility-based "equipment pool".

Communication boards, dedicated speech-generating devices (medical in nature) and related accessories are DME. Artificial larynx, voice amplification, and related devices are prostheses.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-78, "Augmentative Communication Device Selection Report", must be completed and signed by the evaluating speech-language pathologist and the ordering physician. Form MS-78 is submitted with the request for prior authorization.

COMPRESSORS...................... See NEBULIZERS and COMPRESSORS.

CONTINUOUS PASSIVE MOTION (CPM) DEVICES ........ Covered for clients who have received a total knee replacement. To qualify for coverage, use of the device must commence within two days following surgery. Coverage is limited to that portion of the three-week period following surgery during which the device is used in the client's home.

Accessories/Supplies: Payment for rental of CPM devices includes all accessories necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

CONTINUOUS POSITIVE AIRWAY PRESSURE SYSTEMS (CPAP)................. Covered for clients with moderate or severe obstructive sleep apnea for whom surgery is a likely alternative to CPAP.

Intermittent assist devices with CPAP are covered for clients that after trial use with CPAP cannot tolerate use of CPAP without intermittent assist devices.

Humidifiers for use with CPAP are covered for clients that require supplemental humidification with CPAP.
Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of CPAP devices are covered for use with rented and client-owned devices for clients whose condition meets the criteria for coverage of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

CRADLES, ANY TYPE .............. Not covered-not primarily medical in nature.

CRUTCHES ......................... See CANES and CRUTCHES.

DEHUMIDIFIERS, ROOM OR CENTRAL HEATING SYSTEM TYPES.................................. Not covered-environmental control equipment; not primarily medical in nature.

DIALYSIS EQUIPMENT and SUPPLIES .................................. Medicaid reimburses for dialysis systems, related supplies and equipment only to approved renal dialysis facilities under the Medicare Method I (composite rate) payment methodology. Payment cannot be made to suppliers, pharmacies or home health agencies for dialysis systems, related supplies and equipment.

DIATHERMY MACHINES, STANDARD and PULSED WAVE TYPES....................... Not covered-inappropriate for home use.

DRESSINGS ............................. Covered for clients that require treatment of a wound or surgical incision.

Note: Skin/wound cleaners are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

ELECTRICAL NERVE STIMULATORS ...................... See NEUROMUSCULAR ELECTRICAL STIMULATORS; TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS.
ELECTROMYOGRAPHY (EMG) BIOFEEDBACK DEVICES

Covered for muscle re-education of specific muscle groups or for treating pathological muscle spasm, or weakness, when more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for psychosomatic conditions, or for psychiatric conditions.

**Supplies/Accessories:** Payment for purchase and rental of a EMG biofeedback device includes all accessories necessary for proper functioning and effective use of the device. Accessories are payable only as replacement for use with client-owned devices for clients whose condition meets the criteria for coverage of the device.

**Documentation:** See 471 NAC 7-007 for documentation of medical necessity requirements.

ELEVATORS

Not covered-convenience item; not primarily medical in nature.

EMESIS BASINS

Not covered-convenience item; not primarily medical in nature.

ENTERAL NUTRITION

Covered for clients with normal gastrointestinal (G.I.) absorptive capacity who, due to permanent or temporary nonfunction or disease of the structures that normally permit food to reach the small bowel, requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the client's overall health status. **Note:** Permanent impairment is not required for coverage.

Coverage includes enteral nutrients, infusion pumps, feeding supply kits, and nasogastric/gastrostomy/jejunostomy tubes. Enteral feeding supply kits include all the necessary supplies (excluding the tubing) for the enteral patient using the syringe, gravity, or pump method of nutrient administration.
No more than one month supply of enteral nutrients, equipment or supplies may be provided in advance.

If a pump is ordered, there must be documentation to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload).

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Note: For clients eligible for the Supplemental Feeding and Nutrition Program for Women, Infants and Children (WIC), enteral nutrients are covered if the product is not covered by WIC or if the quantity required exceeds the maximum quantity provided by WIC.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is strongly encouraged.

(See also NUTRITIONAL SUPPLEMENTS; PARENTERAL NUTRITION.)

ENURESIS ALARMS ...................... Not covered-not primarily medical in nature.

ENVIRONMENTAL CONTROL EQUIPMENT ...................... Not covered-not primarily medical in nature.

ESOPHAGEAL DILATORS ........ Not covered-physician instrument.

EXERCISE EQUIPMENT .......... Not covered-not primarily medical in nature.
(includes exercise bicycles, Moore wheel, treadmills, weights)

EYE PROSTHESES ............... Covered for clients with absence or shrinkage of an eye due to birth defect, trauma or surgical removal.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

FAMILY PLANNING SUPPLIES ...................... Covered when required to prevent or delay pregnancy.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
FOOT ORTHOSES
(orthopedic shoes, shoe modifications, transfers).............. Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet. Coverage of orthopedic shoes is limited to one pair at the time of purchase. Except when documentation indicates excessive wear or size change necessary due to growth, only one pair of orthopedic shoes is covered in a one year period.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

HEARING AID BATTERIES ........ Covered for clients that use hearing aids.

Note: For policy regarding NMAP coverage of hearing aids, see 471 NAC 8-000.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

HEAT/COLD APPLICATION DEVICES ................................ Covered for clients with medical conditions for which the application of heat or cold is therapeutic.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also PARAFFIN BATH UNITS.)

HEATING and COOLING PLANTS/EQUIPMENT ............ Not covered-environmental control equipment; not primarily medical in nature.
HOSPITAL BEDS

A fixed height hospital bed is one with manual head and leg elevation adjustments, but no height adjustments. A fixed height hospital bed is covered for clients whose condition meets one of the following criteria:

1. Requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month. Elevation of the head/upper body less than 30 degrees does not usually require use of a hospital bed;
2. Requires, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;
3. Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration. Pillows or wedges must have been tried and failed; or
4. Requires traction equipment which can only be attached to a hospital bed.

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments. A variable height hospital bed is covered if the client's condition meets the criteria for coverage of a fixed height hospital bed and the client also requires a bed height different from that provided by fixed height hospital bed in order to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed is one with manual height adjustment and with electric head and leg elevation adjustments. A semi-electric hospital bed is covered if the client's condition meets the criteria for coverage of a fixed height hospital bed and the client also requires frequent changes in body position and/or has an immediate need for a change in body position.

Note: A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments. An electric bed height adjustment feature is not covered; it is a convenience feature. If the documentation supports a lower level bed, payment is based on the allowable for the least costly alternative.
Supplies/Accessories: An innerspring or foam rubber mattress is covered when an integral part of, an accessory to or as a replacement for a medically necessary hospital bed owned by the client.

Side rails are covered when an integral part of, or an accessory to, a medically necessary hospital bed if the client's condition requires bed side rails. (See also BED SIDE RAILS.)

A trapeze bar is covered for clients who need the device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

A bed cradle is covered for clients with acute gouty arthritis or burns for whom it is necessary to prevent contact with the bed coverings.

Note: An overbed table is not covered since it is a convenience item and not primarily medical in nature.

Note: A bed board is not covered since it is not primarily medical in nature.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

HUMIDIFIERS (ROOM OR CENTRAL HEATING TYPE) Not covered—environmental control equipment; not primarily medical in nature. (See also VAPORIZERS.)

IMPOTENCE TREATMENT DEVICES Covered for clients with organic impotence and without conditions that contraindicate use of the device.

Supplies/Accessories: Payment for purchase of the device includes all accessories necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
INCONTINENCE APPLIANCES and CARE SUPPLIES

Covered for clients without control over bladder or bowel function. Incontinence diapers/briefs and liners are not covered for clients under age 3.

Note: Skin cleansers are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

INFUSION PUMPS, EXTERNAL

Covered for clients with conditions which require administration of parenteral medication when reasonable and necessary, and when an infusion pump is necessary to safely administer the medication.

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Insulin Infusion pumps, Continuous Subcutaneous (CSII):

Purchase is covered on a prior authorization basis based on medical necessity. The provider shall obtain written documentation from the prescribing physician which includes at minimum, the following:

1. Diabetes Team Evaluation Summary: Letter from the prescribing physician who is part of a diabetes team; (the team must include at minimum a physician with expertise in diabetes and a diabetic health educator) must address at minimum:
   a. Diagnosis;
   b. Complications/Compounding issues;
   c. Failure of adequate blood glucose control in spite of demonstrated compliance with multiple daily injections;
   d. Hgb A1c levels; and
   e. Patient's ability and motivation to use the pump.

2. Treatment plan: A comprehensive plan of care for the client utilizing the CSII which includes:
   a. Inpatient initiation of CSII or rationale for outpatient initiation with all policies and procedures involved;
   b. Client/family diabetes education plan; and
   c. Monitoring plan post-initiation of CSII.
Supplies/Accessories: Supplies necessary for effective use and proper functioning of an external infusion pumps are covered for use with rented and client-owned pumps for clients whose condition meets the criteria for coverage of the pump.

Note: For billing of medications administered with external infusion pumps, see 471 NAC 16-000, Pharmacy Services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also ENTERAL NUTRITION; PARENTERAL NUTRITION.)

INJECTORS (hypodermic jet pressure powered devices for injection of insulin) ...................... Not covered-effectiveness not adequately demonstrated.

INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) MACHINES...................... Covered for clients whose ability to breathe is severely impaired.

Supplies/Accessories: Payment for purchase and rental of an IPPB machine includes all accessories necessary for proper functioning and effective use of the machine. Accessories are payable only as replacement for use with client-owned devices for clients whose condition meets the criteria for coverage of the machine.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

LIFTS, PATIENT ...................... Covered for clients when transfer between bed and a chair, wheelchair or commode requires the assistance of more than one person or without the use of a lift, the client would be bed confined.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Documentation must verify the client can use the lift and has had a successful trial, if first time user.

Prior Authorization: Prior authorization of payment is not required.

(See also BATH and TOILET AIDS; SEAT LIFT CHAIRS.)
LIFTS, WHEELCHAIR/ EQUIPMENT ....................... Not covered—convenience item; not primarily medical in nature.

LOW AIR LOSS BED UNITS...... See AIR FLUIDIZED and LOW AIR LOSS BED UNITS.

LOWER and UPPER LIMB ORTHOSES...................... Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

LOWER and UPPER LIMB PROSTHESES .................... Covered when required to replace a missing body part.

Note: Myoelectric and electronically switch controlled prosthetic devices are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

LYMPHEDEMA PUMPS ............. See PNEUMATIC COMPRESSORS.

MASSAGE DEVICES ............... Not covered—comfort item; not primarily medical in nature.

MATTRESS/PILLOW COVERS ......................... Not covered—not primarily medical in nature.

MEDICAL IDENTIFICATION ITEMS ....................... Not covered—do not serve a diagnostic or therapeutic purpose.

MEDICAL/SURGICAL SUPPLIES ......................... Covered for clients that require home treatment of a specific medical condition, protection or support of a wound, surgical incision or diseased or injured body part.

Note: Skin/wound cleansers and "ready to use" disinfectant cleaning solution are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also DRESSINGS; INCONTINENCE APPLIANCES and CARE SUPPLIES; OSTOMY SUPPLIES; TRACHEOSTOMY CARE SUPPLIES.)
NEBULIZERS and COMPRESSORS

Covered if the client's ability to breathe is severely impaired, to administer aerosol therapy when use of a metered dose inhaler is not adequate or appropriate, or when required for use in connection with durable medical equipment for purposes of moisturizing oxygen.

Heated nebulizers are covered for clients with tracheostomies that require heated oxygen.

Portable compressors with internal battery features require specific documentation from the physician justifying the medical necessity of the portable feature.

Ultrasonic nebulizers are covered only when other means of nebulization is documented by the physician to be ineffective.

Note: For nebulizers and humidifiers for use with a flow meter or regulator, see OXYGEN and OXYGEN EQUIPMENT.

Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of a nebulizer or compressor are covered for use with rented and client-owned equipment for clients whose condition meets the criteria for coverage of the compressor. Note: Distilled water is not covered. For billing of medications for inhalation therapy, see 471 NAC 16, Pharmacy Services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

NEUROMUSCULAR ELECTRICAL STIMULATORS (NMES)

Covered for treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy. Some examples would be castings or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). Note: Neuromuscular electric stimulators are not covered for treatment of scoliosis.

A conductive garment for use with a NMES unit may be covered when medical necessity is sufficiently substantiated.
Supplies/Accessories: NMES supplies are covered for use with rented and client-owned NMES units for clients whose condition meets the criteria for coverage of the unit. For rented NMES units, the lead wires and supplies must be billed on the same claim as the NMES rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

NUTRITIONAL SUPPLEMENTS

Covered for clients who require nutritional supplementation to maintain weight and strength commensurate with the client's general condition.

Note: Infant formula for oral nutritional supplements is covered for clients age 20 and younger only if medically necessary for special dietary needs (e.g., soy based, low iron, premature, etc.)

Note: For clients eligible for the Supplemental Feeding and Nutrition Program for Women, Infants and Children (WIC), nutritional supplements are covered if the product is not covered by WIC or if the quantity requirement exceeds the maximum quantity provided by WIC.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also ENTERAL NUTRITION; PARENTERAL NUTRITION.)

OCULAR PROSTHESES

See EYE PROSTHESES.

ORTHOPEDIC SHOES

See FOOT ORTHOSES.

ORTHOSES

See FOOT ORTHOSES; UPPER and LOWER LIMB ORTHOSES.

OSTEOGENIC STIMULATORS (NONINVASIVE)

Covered for client's with one of the following indications -

1. Nonunion of long bone fractures;
2. Failed fusion; and
3. Congenital pseudoarthrosis.

Nonunion of long bone fractures is considered to exist only after six or more months.
A failed fusion is considered to exist only after 6 months or more have elapsed without healing of the fusion.

**Supplies/Accessories:** Payment for osteogenic stimulators includes all accessories and supplies necessary for proper functioning and effective use of the device.

**Documentation:** See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

**OSTOMY SUPPLIES**

Covered for clients with an ostomy.

Skin moisturizers, protectants and sealants are covered only if medically necessary for clients with ostomies.

**Note:** Skin cleansers are not covered.

**Documentation:** See 471 NAC 7-007 for documentation of medical necessity requirements.

**OVERBED TABLES**

Not covered—convenience item; not primarily medical in nature.

**OXIMETERS, EAR/PULSE**

Covered on a rental basis for clients who require a minimum of daily monitoring of arterial blood oxygen saturation levels for evaluation and regulation of home oxygen therapy. Coverage for other indications will be determined on a case-by-case basis.

**Note:** In-home overnight (12 hour or similar) oximetry trend studies and other single test ("one time") oximetry testing is not covered.

**Supplies/Accessories:** During rental of an oximeter, supplies and accessories necessary for proper functioning and effective use of the device are included in the rental allowance.
Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The documentation must specify:

1. The client's medical condition which substantiates the need for in-home use of oximeter;
2. The estimated length of need for monitoring; and
3. The frequency of monitoring required (e.g., continuous, daily, etc.).

A monthly updated certification of medical necessity is required when the oximeter is required for evaluation and regulation of home oxygen therapy.

OXYGEN and OXYGEN EQUIPMENT

Covered for clients with significant hypoxemia in the chronic stable state provided the following conditions are met:

1. The attending physician has determined that the client suffers severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy;
2. The client's blood gas levels indicate the need for oxygen therapy; and
3. The client has appropriately tried other alternative treatment measures without complete success.

Oxygen therapy is covered for clients with significant hypoxemia evidenced by any of the following:

1. An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken -
   a. at rest;
   b. during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, while awake, or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent) associated with symptoms or signs reasonable attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for nocturnal use of oxygen; or
c. during exercise for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air; or

2. An arterial PO2 of 56 to 59 mm Hg or an arterial blood oxygen saturation of 89 percent if any of the following are documented -
   a. Dependent edema suggesting congestive heart failure;
   b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, "P" pulmonale of EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or
   c. Erythrocythemia with a hematocrit greater than 56 percent.

Oxygen therapy is not covered for -

1. Angina pectoris in the absence of hypoxemia;
2. Dyspnea without cor pulmonale or evidence of hypoxemia;
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities; and
4. Terminal illness that does not affect the lungs.

Portable oxygen systems alone or to complement a stationary oxygen system may be covered if the client is mobile within the residence.

Respiratory therapists' services are not covered. The durable medical equipment benefit provides for coverage of oxygen and oxygen equipment, but does not include a professional component in the delivery of such services.

Note: The following items are not covered since they are precautionary and not therapeutic in nature -

1. Spare tanks of oxygen;
2. Emergency oxygen inhalators; and
3. Preset portable oxygen delivery unit (where flow rate is not adjustable).
Note: Piped-in oxygen delivery is not considered an acceptable delivery mode for reimbursement as durable medical equipment.

Oxygen therapy includes the oxygen contents, the system for furnishing it, the vessels that store it, and the tubing and administration sets that allow the safe delivery of oxygen.

When a both stationary and portable system is being rented, the allowable for all contents is included in the allowable for the stationary system. Stationary contents are payable only when the client owns the gaseous or liquid stationary system. Portable contents are payable only when the client uses a portable system only (either rented or owned).

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is required. Documentation must include the results of a blood gas study that has been ordered and evaluated by the attending physician. This will usually be in the form of a measurement of the partial pressure of oxygen (PO2) in the arterial blood. A measurement of pulse arterial oxygen saturation may also be acceptable when ordered and evaluated by the attending physician and performed under his/her supervision or when performed by a qualified provider or supplier of laboratory services. Note: A DMEPOS supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines. When a client's initial certification for oxygen is approved based on an arterial PO2 of 56 mm Hg or greater or an oxygen saturation of 89% or greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity.

Supplies/Accessories: Oxygen supplies/accessories (e.g., tubing, administration sets, etc.), are payable only as replacement for use with client owned delivery systems for clients whose condition meets the criteria for coverage of oxygen therapy.

Prior Authorization: Prior authorization of payment is not required.

Billing Requirements: When billing for oxygen therapy, the DMEPOS provider shall use the appropriate unit of service as described in the procedure code. Units of service should be rounded to the nearest unit of the procedure code description.
PACEMAKER MONITORS, 
SELF CONTAINED
Covered for clients with cardiac pacemakers.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PARAFFIN BATH UNITS, 
PORTABLE
Covered for clients with conditions that are expected to be relieved by long term use of this modality and who have undergone a successful trial period of paraffin therapy.

Supplies/Accessories: Paraffin is covered for use with rented and client-owned paraffin bath units for clients whose condition meets the criteria for coverage of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

PARALLEL BARS
Not covered—support exercise equipment; primarily for institutional use; in the home setting, other devices (e.g., walkers) available to meet client's needs.

PARENTERAL NUTRITION
Covered for clients with severe permanent or temporary disease of the gastrointestinal tract which prevents absorption of sufficient nutrients to maintain weight and strength commensurate with the client's overall health status.

Coverage includes parenteral nutrition infusion pumps, supply and administration kits, and parenteral nutrients. Parenteral supply and administration kits include all the components necessary to administer therapy.

No more than one month supply of parenteral nutrients, equipment or supplies may be provided in advance.

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Note: For clients eligible for the Supplement Feeding and Nutrition Program for Women, Infants and Children (WIC), parenteral nutrients are covered if the product is not covered by WIC or if the quantity required exceeds the maximum quantity provided by WIC.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
PEAK FLOW METERS

Covered for clients with chronic asthma.

**Documentation:** See 471 NAC 7-007 for documentation of medical necessity requirements.

PERCUSSORS

Covered for mobilizing respiratory tract secretions in clients with cystic fibrosis, chronic obstructive lung disease, chronic bronchitis, or emphysema, when the client or operator of powered percussor has received appropriate training by a physician or therapist and no one competent to administer manual therapy is available.

**Documentation:** See 471 NAC 7-007 for documentation of medical necessity requirements.

PHOTOTHERAPY SERVICES

Covered on a rental basis for infants that meet the following criteria -

1. Neonatal hyperbilirubinemia is the infant's sole clinical problem;
2. The infant is greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gm (5 lbs);
3. The infant is greater than 48 hours of age;
4. Bilirubin level at initiation of phototherapy (greater than 48 hours of age) is 14-18 mgs per deciliter; and
5. Direct bilirubin level is less than 2 mgs per deciliter.

Home phototherapy is not covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.

The following conditions must be met prior to initiation of home phototherapy -

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

Payment: Medicaid daily rental payment includes -

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

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. A physician's narrative report outlining the client's progress and the circumstances necessitating extended therapy must be submitted with the claim when billing for home phototherapy exceeding three days.

Billing Requirements: The provider shall bill for home phototherapy daily rental on a single claim and indicate the total number of rental days as the units of service.

PILLOWS .........................
Not covered-convenience item; not primarily medical in nature. (See also BED WEDGES; TRACTION EQUIPMENT.)

PNEUMATIC COMPRESSORS and APPLIANCES ....................
Covered for clients with intractable edema of the extremities.
Rental of a pneumatic appliance is not covered because the item is intended for single-person use.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.
POSTURAL DRAINAGE
BOARDS .......................... Covered for clients with chronic pulmonary conditions.

Documentation:  See 471 NAC 7-007 for documentation of medical necessity requirements.

PRESSURE REDUCING
SUPPORT SURFACES.......... Pressure reducing mattress pads/overlays are covered when the client meets one of the following criteria -

1. Completely immobile (i.e., the client cannot make changes in body position without assistance);
2. Limited mobility (i.e., the client cannot independently make changes in body position significant enough to alleviate pressure); or
3. Any stage pressure ulcer on the trunk or pelvis.

If the client meets criteria 2 or 3 above, the client must also meet at least one of the following criteria -

a. Impaired nutritional status;
b. Fecal or urinary incontinence;
c. Altered sensory perception; or
d. Compromised circulatory status.

Pressure reducing mattress replacements are covered when the client meets the coverage criteria for a pressure reducing mattress pad/overlay and -

1. Anticipated length of need is at least one year; or
2. "Bottoming out" is anticipated on a comparable pad/overlay. "Bottoming out" is the finding that the client's body will be in contact with a flat outstretched hand (palm up) that is placed underneath the support surface in various body positions.

Note:  Powered mattress pads/overlays and mattress replacements, except alternating pressure pads, are not covered.
The client must also have a care plan established by the physician or other licensed healthcare practitioner directly involved in the client's care which should include the following:

1. Education of the client and caregiver on the prevention and/or management of decubiti;
2. Regular assessment by a licensed health healthcare practitioner;
3. Appropriate turning and positioning;
4. Appropriate wound care (for stage II, III, or IV ulcer);
5. Moisture/incontinence control, if needed; and
6. Nutritional assessment and intervention consistent with the overall plan of care if there is impaired nutritional status.

Adherence to the care plan/treatment is not to be construed as elements for coverage criteria.

Pressure reducing cushions are covered for clients with or highly susceptible to decubiti and whose physician will be supervising its use in connection with his/her course of treatment.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The client's physician must have prescribed the item for treatment must specify in the prescription that s/he will be supervising its use in connection with the client's course of treatment. Use of Medicare CMN form is strongly encouraged.

(See also AIR FLUIDIZED and LOW AIR LOSS BED UNITS.)

PROSTHESES

See BREAST PROSTHESES; EYE PROSTHESES; UPPER and LOWER LIMB PROSTHESES.

PULSE TACHOMETERS

Not covered-not reasonable or necessary for monitoring pulse of client with or without a cardiac pacemaker.

REPAIR

See 471 NAC 7-010.06 for repair policy.
RESTRAINTS, ANY TYPE ........ Not covered-not primarily medical in nature.  (including body, chest, wrist, ankle, or for use in cars)

SAUNA BATHS........................ Not covered-not primarily medical in nature.

SEAT LiftS......................... Covered if all the following criteria are met -

1. The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease;
2. The seat lift chair must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the client's condition;
3. The client must be completely incapable of standing up from a regular armchair or any chair in their home; and
4. Once standing, the client must have the ability to ambulate.

Coverage is limited to those types which operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to standing position.

Payment: Payment for seat lift chairs which incorporates a recliner feature along with the seat lift is limited to the amount payable for a seat lift without this feature.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Medicare/ Medicaid Clients: For clients eligible for both Medicare and Medicaid, the seat portion of the seat lift chair will be covered by if Medicaid the seat lift mechanism has been approved by Medicare. Prior authorization of payment is not required. Documentation of Medicare coverage (remittance advice or coordination of benefits) must be submitted on or with the Medicaid claim when billing for the chair portion.
SHEETS, DISPOSABLE OR REUSABLE ................................. Not covered—convenience item; not primarily medical in nature.

SHOWER ATTACHMENTS, HANDHELD ............................... Not covered—hygienic equipment; not primarily medical in nature.

SITZ BATHS .......................................................... Covered for clients with infection or injury of the perineal area and use of the item is part of the physician ordered planned regimen of treatment in the client's home.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirement.

SPEECH TEACHING MACHINES ............................... Not covered—education equipment; not primarily medical in nature.

SPINAL ORTHOSES ............................... Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured body part.

A seating system, back module for use with a wheelchair is covered when medically necessary for use with a medically necessary wheelchair base, for a client who has a diagnosed medical condition that impairs their ability to sit. A wheelchair seating system may be covered for the purpose of:

1. Supporting the client in a position that minimizes the development or progression of musculoskeletal impairment; 
2. Relieving pressure; or 
3. Providing support in a position that improves the client's ability to perform functional activities.

An evaluation of the client's wheelchair seating needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of wheelchair seating system; and 
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.
Form MS-79 must be reviewed and signed by a physician involved in the client's care. **Note:** This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the wheelchair will be required on a short-term basis only.

**Documentation:** See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

**STAIRWAY ELEVATORS**

Not covered—convenience item; not primarily medical in nature.

**STOCKINGS, SURGICAL**

See SUPPORTS.

**SUCTION PUMPS**

Covered for clients who have difficulty raising and clearing secretions secondary to -

1. Cancer or surgery of the throat or mouth;
2. Dysfunction of the swallowing muscles;
3. Unconsciousness or obtunded state; or
4. Tracheostomy.

**Supplies/Accessories:** Supplies and accessories necessary for effective use and proper functioning of a suction pump are covered for use with rented and client-owned suction pumps for clients whose condition meets the criteria for coverage of the pump.

**Documentation:** See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

(See also TRACHEOSTOMY CARE SUPPLIES.)
SUPPORTS (including elastic supports, elastic/surgical stockings, slings, trusses, etc.)... Covered for post-surgical clients, and clients with intractable edema of the lower extremities or other circulatory disorders.

Note: Support pantyhose are not covered.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

TELEPHONE ALERT SYSTEMS ......................... Not covered-these are emergency communication systems and do not serve a diagnostic or therapeutic purpose.

TELEPHONE ARMS..................... Not covered-convenience item; not primarily medical in nature.

TOOTHBRUSHES................. Not covered-personal hygiene item.

TRACHEOSTOMY CARE SUPPLIES ....................... Covered for clients with an open surgical tracheostomy.

A tracheostomy care or cleaning starter kit is covered following an open surgical tracheostomy for a two week post-operative period.

An artificial larynx is covered for clients that have had a laryngectomy or whose larynx is permanently inoperable.

Artificial larynx and tracheostomy speaking valves are prostheses.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

TRACTION EQUIPMENT .......... Covered for clients with orthopedic impairments requiring traction equipment that prevents ambulation during the period of use.

Cervical pillows are covered only when required for use with traction equipment.

Supplies/Accessories: Payment for purchase and rental of traction equipment includes all accessories necessary for proper functioning and effective use of the equipment. Accessories are payable only as replacement for use with client-owned traction equipment for clients whose condition meets the criteria for the equipment.
Documented: See 471 NAC 7-007 for documentation of medical necessity requirements.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS) . Covered for clients with chronic, intractable pain or acute post-operative pain who meet the following criteria:

- The presumed etiology of the pain must be a type which is accepted as responding to TENS therapy.
- For chronic, intractable pain, the medical record must document the location of the pain, the duration of time the patient has had the pain and the presumed etiology of the pain. The pain must have been present for at least 3 months.
- Other appropriate treatment modalities must have been tried and failed and the medical record must document what treatment modalities have been used (including the names and dosage of medication), the length of time that each type of treatment was used and the results. The TENS unit must be used by the client on a trial basis for a minimum of one month, but not to exceed two months. This trial period may not begin sooner than the end of the 3 months used to establish the existence of chronic pain. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the client at the end of the trial period and must indicate how often the client used the TENS unit, the typical duration of use each time, and the results.
- A TENS unit is not covered for acute pain (less than 3 months duration) other than post-operative pain. For acute post-operative pain, a TENS unit is generally covered for no more than one month following the day of surgery. Approval for more than one month will be determined on a case-by-case basis, based on the documentation provided by the attending physician and submitted with the prior authorization request.
A four-lead TENS unit may be used with either 2 lead or 4 leads, depending on the character of the patient’s pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the client's needs.

A conductive garment for use with a TENS unit may be covered when medical necessity is sufficiently substantiated.

Supplies/Accessories: TENS supplies are covered for use with rented and client-owned TENS units for clients whose condition meets the criteria for coverage of the unit. If the TENS unit is used less than daily, the frequency of billing for the TENS supplies must be reduced proportionally. For rented TENS units, the supplies must be billed on the same claim as the TENS rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

TRANSFER EQUIPMENT ............ Covered for clients that require assistance with transfer.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also LIFTS, PATIENT; WHEELCHAIR OPTIONS/ACCESSORIES.)

TRAPEZE EQUIPMENT ............. Covered when required for clients to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

(See also HOSPITAL BED ACCESSORIES.)

ULTRAVIOLET CABINETS ........ Covered for clients with generalized, intractable psoriasis. Documentation must justify treatment at home rather than alternative site (e.g., the outpatient department of a hospital).

Documentation: 471 NAC 7-007 for documentation of medical necessity requirements.

URINALS............................. See BEDPANS and URINALS.
UTERINE MONITORS,
HOME........................................

Covered on a rental basis for clients that meet the following criteria -

1. The client is at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy;
2. The pregnancy must be greater than 20 weeks gestation; and
3. The client must have one of the following medical conditions -
   a. Recent preterm labor with hospitalization and discharge on tocolytic therapy;
   b. Multiple gestations;
   c. History of preterm delivery;
   d. Anomalies of the uterus;
   e. Incompetent cervix;
   f. Previous cone biopsy;
   g. Polyhydramnios; or
   h. Diethylstilbestrol exposure.

Others at high risk for preterm labor and delivery may be covered upon approval by the Medicaid Medical Director through written communication from the client's physician (preferably in consultation with a perinatologist).

Uterine monitoring is not covered after completion of the 36th week of pregnancy.

The following conditions must be met prior to provision of uterine monitors -

1. Comprehensive client assessment and evaluation by the attending physician has occurred; and
2. Client has successfully completed training on use of equipment.

Payment: Medicaid rental payment includes all equipment, supplies and services necessary for the effective use of the monitor. This does not include medications or physician's professional services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Billing Requirements: The provider shall indicate on the claim the condition which necessitates use of the monitor and, when billing for the final rental period, the date of discontinuation of the monitor.
VAPORIZERS, ROOM TYPE ........................................... Covered for clients with a respiratory illness. Coverage includes "cool mist" and "warm mist" vaporizers.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

VEHICLE, POWER-OPERATED (POV) ........................................... A power-operated vehicle (POV) is covered instead of a manual wheelchair when all of the following criteria are met -

1. The client has a diagnosed medical condition which impairs their ability to walk;
2. The client requires a POV for the purpose of -
   a. Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. They include, but are not limited to: caring for oneself, mobility, learning, working, performing manual tasks, breathing, seeing, and communicating; or
   b. Providing assisted mobility for clients who show no means of safe independent mobility.
3. The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client's use of a POV must result in a significant improvement in independent mobility and ability to perform major life activities; and
4. The client has demonstrated, through a trial period with a similar POV -
   a. the ability to safely and independently operate the controls of a POV;
   b. the ability to transfer safely in and out of a POV; and
   c. adequate trunk stability to be able to safely ride in the POV.
An evaluation of the client’s wheelchair needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of POV as well as any options or accessories; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Form MS-79 must be reviewed and signed by a physician involved in the client's care. Note: This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the POV will be required on a short-term basis only.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

VENTILATORS

Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, chronic respiratory failure consequent to chronic obstructive pulmonary disease and respiratory paralysis.

Supplies/Accessories: Payment for rental of ventilators includes all accessories necessary for proper functioning and effective use of the device. Accessories are payable only as replacement for use with client-owned ventilators for clients whose condition meets the criteria for the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
WALKERS ................................
Covered for clients with conditions that impair ambulation and there is a need for greater stability and security than provided by a cane or crutches.

A heavy duty, multiple braking system, variable wheel resistance walker is covered for clients who are unable to use a standard walker due to obesity, severe neurologic disorders, or restricted use of one hand.

Supplies/Accessories: Payment for purchase and rental of walkers includes all accessories necessary for proper functioning and effective use of the item. Accessories such as tips, handgrips, etc., are payable only as replacement for use with client-owned walkers for clients whose condition meets the criteria for coverage of the item.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

WHEELCHAIRS, (MANUAL and POWER).............
A manual wheelchair is covered for clients who meet the following criteria -

1. The client has a diagnosed medical condition which impairs their ability to walk; and
2. The client requires a wheelchair for the purpose of -
   a. Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. They include, but are not limited to: caring for oneself, mobility, learning, working, performing manual tasks, breathing, seeing, and communicating; or
   b. Providing assisted mobility for clients who show no means of safe independent mobility.
A **powered wheelchair** is covered instead of a manual wheelchair if the client meets the criteria for a manual wheelchair and -

1. The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client’s use of a powered wheelchair must result in a significant improvement in independent mobility and ability to perform major life activities; and
2. The client has demonstrated, through a trial period with a similar powered wheelchair, the ability to safely and independently operate the controls of a powered wheelchair.

An evaluation of the client's wheelchair needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of wheelchair as well as any options or accessories; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Form MS-79 must be reviewed and signed by a physician involved in the client's care. **Note:** This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the wheelchair will be required on a short-term basis only.
Options/Accessories: Wheelchair options/accessories are covered when medically necessary for use with a medically necessary, rented or client-owned wheelchair base.

A wheelchair seating system is covered when medically necessary for use with a medically necessary wheelchair base, for a client who has a diagnosed medical condition that impairs their ability to sit. A wheelchair seating system may be covered for the purpose of -

1. Supporting the client in a position that minimizes the development or progression of musculoskeletal impairment;
2. Relieving pressure; or
3. Providing support in a position that improves the client's ability to perform functional activities.

A reclining back wheelchair frame is one in which the angle between the seat and the back of the frame is adjustable between 90 and 180 degrees. It may include elevating leg rests. A reclining back may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

A tilt-in-space wheelchair frame is one in which the angle between the seat and the back remain relatively fixed, but the seat and back pivot as a unit away from the fully upright position, such that the angle that both the seat and back make with the ground is able to be adjusted, usually more than 30 degrees. A tilt-in-space wheelchair frame may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

Reclining back or tilt-in-space wheelchair frames are covered for clients that -

1. Have a diagnosed medical condition which impairs their ability to tolerate the fully upright sitting position for significant amounts of time (usually greater than two hours);
2. Need to remain in a wheelchair for purposes of mobility or other interaction with their environment; and
3. Require frequent, significant adjustment of their position in the wheelchair, either to change hip angle or their sitting position relative to the ground.
Power operation of the reclining or tilt-in-space mechanism, which may include power operated elevating legrests, is covered for clients that meet the criteria for a reclining or tilt-in-space mechanism and:

1. Have the cognitive and motor ability to operate the required control switch(es); and
2. Are routinely in situations (e.g., home, community, school, work, etc.) where caregivers are not available within a reasonable time to manually recline or tilt them as needed.

Combination power recline/tilt-in-space frames, if unavailable in manually operated forms, are covered for clients that require both recline and tilt-in-space features (e.g., lack of necessary passive hip flexion for use of a standard tilt-in-space or inability to tolerate a significantly greater hip extension angle during sitting).

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

(See also SPINAL ORTHOSES - Seating Systems and Back Modules; Vehicles, Power Operated.)
WHIRLPOOL BATH EQUIPMENT, STANDARD (BUILT-IN TYPE)  
Covered for clients who are homebound and have a condition for which the whirlpool bath is expected to provide substantial therapeutic benefit to justify its cost. Where the client is not homebound, but has such a condition, payment is restricted to providing the services elsewhere (e.g., an outpatient department of a hospital) if that alternative is less costly.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

WHIRLPOOL PUMPS, PORTABLE  
Not covered—not primarily medical in nature; generally used for soothing or comfort purposes.

WOUND THERAPY NEGATIVE PRESSURE  
Negative Pressure Wound Therapy is covered for clients with stage 4 decubiti, which does not respond to usual wound dressing. This is a rental in which the provider is responsible for training the client, caregivers or facility staff and monitoring the use of the equipment.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

NOT OTHERWISE CLASSIFIED (NOC) CODES  
Coverage of items for which no specific procedure code exists will be determined on a case-by-case basis.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.
CHAPTER 8-000  HEARING AIDS

8-001 Standards for Participation: Hearing aid dispensers must be licensed by the Nebraska Department of Health and Human Services or if the services are provided outside Nebraska, the dispenser must be licensed by the appropriate agency of the state in which s/he practices. To participate in the Nebraska Medical Assistance Program (NMAP), hearing aid dispensers must complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval.

8-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

8-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider must provide services only under arrangement with the HMO.

8-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. For services which require NMAP prior authorization (see 471 NAC 8-007), the provider must contact the PCCM plan and request authorization as directed by the plan. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

8-003 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Division of Medicaid and Long-Term Care.

8-004 Covered Services: NMAP considers coverage for hearing aids, hearing aid repairs, hearing aid rental, assistive listening devices, and other hearing aid services when the services are medically necessary and are prescribed by a physician.

NMAP covers standard in-the-ear, behind the ear, or body hearing aids. Bone conduction aids will be approved with Ear, Nose and Throat (E.N.T.) Specialist approval.
8-005 Non-Covered Services: NMAP does not cover hearing aid batteries for residents of a nursing facility except with the initial fitting. NMAP does not cover accessories which are for convenience and not medically necessary, or in-the-canal (ITC) or completely in the canal (CIC) hearing aids.

8-006 Ear, Nose and Throat (E.N.T.) Evaluations: NMAP requires that a client be evaluated by an E.N.T. when the following criteria is met:

1. The client has a conductive hearing loss;
2. The client has a unilateral hearing loss; or
3. The client is age 16 or younger.

8-007 Limitations and Requirements for Certain Services

8-007.01 Number of Hearing Aides NMAP May Consider for Payment:

1. For clients age 20 and younger: Hearing aides required by medical necessity. Medical necessity is determined using 471 NAC 8-007.03, Prior Authorization Process.
2. For clients age 21 and older: Hearing aides are limited to not more than one aid per ear every four years and then only when medically necessary. Medical necessity is determined using 471 NAC 8-007.03 Prior Authorization Process.

8-007.02 Prior Authorization: The Department requires prior authorization for all hearing aids and assistive listening devices billed at $500.01 or greater. Prior authorization is also required for all hearing aid repairs and accessories of $150 or greater per line item. If the cost of the repair and batteries is less than $150, no prior authorization is required.

Note: For hearing aides and assistive listening devices billed at $500 or less, prior authorization is not required. However, the provider must secure all the information required by 471 NAC 8-007.03, including Form DM-5H. Rather than submit with a prior authorization, the provider must retain this information for four years, subject to Department review.

8-007.03 Prior Authorization Procedures: NMAP requires that the following information be submitted when requesting prior authorization for a hearing aid or assistive listening device.

1. A complete audiogram (pure tone, air bone, masking, speech);
2. The name of the examiner or dispenser performing the audiogram;
3. The type of hearing aid or assistive listening device being recommended and any accessories;
4. The estimated cost of the hearing aid or assistive listening device;
5. The estimated cost of each accessory;
6. The hearing aid dispenser's provider number; and
7. The hearing aid dispenser's name, address and phone number.

Form DM-5H "Physician's Report on Hearing Loss," (see 471-000-3 must be used when submitting a request for prior authorization. The examining physician must complete the front portion of Form DM-5H. The back portion of Form DM-5H must be completed by either the examiner or the hearing aid dispenser.
The provider must submit requests for prior authorization 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) or by completing and submitting Form MC-9S, "Prior Authorization Document for Hearing Aids" (see 471-000-205 for completion instructions).

Prior authorization is obtained from the Medicaid Division.

8-007.04 Replacement of Hearing Aids and Assistive Listening Devices: The provider must obtain prior authorization from the Medicaid Division for all replacements of lost or stolen hearing aids or assistive listening devices.

8-008 Payment for Hearing Aid Services: The Nebraska Medical Assistance Program (NMAP) pays for covered hearing aid services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The invoice cost (indicated as "IC" in the fee schedule);
   b. The maximum allowable dollar amount; or
   c. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

8-008.01 Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of revisions and their effective dates.

8-009 Billing Requirements: Hearing aid providers must submit claims to the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The provider or the provider's authorized agent must submit the provider's usual and customary charge for each procedure code listed on the claim.

8-010 Procedure Codes: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-508).
CHAPTER 9-000  HOME HEALTH AGENCIES

9-001 Standards for Participation: The home health agency shall complete and sign Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90), and submit the form to the Nebraska Department of Health and Human Services Finance and Support for approval to participate in the Nebraska Medical Assistance Program (NMAP).

9-001.01 Definition of Home Health Agency: Home health agency means a proprietary or nonproprietary agency or organization, or a part of an agency or organization, who is licensed and meets the requirements for participation in Medicare or the Joint Commission on Accreditation of Healthcare Organization.

9-001.02 Purpose: NMAP covers home health agency services to assist clients attain or retain their capacity for independence or self-care in the least restrictive environment by providing payment -

1. For the most appropriate and cost effective medical care necessary to maintain, rehabilitate, or improve the clients' quality of life;
2. To agencies who meet Medicare certification by the Nebraska Department of Health and Human Services Regulation and Licensure, accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) for home health agencies, or to agencies licensed/certified/accredited in other states; and
3. For medical services provided to medically and categorically needy clients who are eligible for NMAP.

9-002 Covered Services: NMAP covers the following home health agency services:

1. Skilled nursing services by -
   a. A registered professional nurse; or
   b. A licensed practical nurse;
2. Home health aide services;
3. Physical therapy provided by a licensed physical therapist (see 471 NAC 17-000);
4. Speech therapy provided by a licensed speech pathologist (see 471 NAC 23-000);
5. Occupational therapy provided by a licensed/certified occupational therapist (see 471 NAC 14-000); and
6. Durable medical equipment and medical supplies (see 471 NAC 7-000).

See 471 NAC 9-002.08 for specific guidelines for NMAP's coverage of home health agency services and 471 NAC 9-002.08A for limitations.

9-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.
9-002.01A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

9-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. In addition, services provided by a home health agency require referral from the client's primary care physician (PCP) and prior authorization by the PCCM Network Administrator. Providers shall contact the PCP before providing services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

9-002.02 Medical Necessity: All home health services must be -

1. Necessary to a continuing medical treatment plan;
2. Prescribed by a licensed physician; and
3. Recertified by the licensed physician at least every 60 days.

Therapies must be recertified every 30 days by the licensed physician.

Durable medical equipment and medical supplies must meet the guidelines outlined in 471 NAC 7-000.

9-002.03 Definition of Home Health Service: Home health services are services provided to a client in the client's place of residence. The residence does not include a hospital, skilled nursing facility, or nursing facility.

A client who requires and is authorized to receive extended-hour home health nursing services in the home setting may use his/her approved hours outside of the home during those hours when his/her normal life activities take him/her out of the home, i.e., attend school, therapeutic activities, etc. The Department will not authorize any additional hours of nursing service beyond what would normally be authorized. If a client wishes to receive nursing services to attend school or other activities outside the home, but does not need nursing services in the home, nursing services cannot be authorized.

To be eligible for home health services, the attending physician shall certify that -

1. Based on the client's medical condition, Home Health services are medically necessary and appropriate services to be provided in the home;
2. Extended home nursing/aide services are medically necessary; or
3. That observation/teaching in the home environment is an integral and necessary part of the plan.
9-002.04 Plan of Care and Treatment Record: The home health agency shall maintain a clinical record that includes the plan of care signed by the physician responsible for the client's care. The attending physician and home health agency personnel shall review the total plan of treatment at least every 60 days.

The home health agency shall maintain these records on all NMAP clients and make them readily available upon the Department's request.

9-002.05 Home Health Aides: A home health aide may provide services to a client in the client's home to meet personal care needs resulting from the client's illness or disability if the care is not available to the client without payment by NMAP. The services must be:

1. Necessary to continuing a medical treatment plan;
2. Prescribed by a licensed physician;
3. Recertified by the licensed physician at least every 60 days; and
4. Supervised by a registered nurse.

9-002.05A Services: Home health aide services may include:

1. Helping the client to assume recommended responsibility and to follow other medical recommendations;
2. Preparing and serving special food;
3. Helping the patient with the care of the mouth, skin, and hair; and
4. Assisting the patient with eating, dressing, getting in and out of bed, bathing, etc.

Skilled nursing visits are not a prerequisite for the provision of home health aide services.

9-006 Limitation: For extended-hour aide services, the Department generally limits aide services to 56 hours/week (8 hrs/day x 7 days/wk). Central Office approval must be obtained for services in excess of 56 hours per week.

The client's needs must be assessed to determine whether the needs can best be met by an aide visit or a minimum block of 4 hours of extended-hour aide services.

9-002.07 Prefilling Insulin Syringes: The Department reimburses home health agencies for prefilling insulin syringes for blind or disabled diabetic clients who are unable to perform this task themselves and there is no one else available. The Department considers this a professional nursing service which may be provided only through a professional nurse visit.
9-002.08 Guidelines for Coverage:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>NMAP COVERS:</th>
<th>NMAP DOES NOT COVER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medications</td>
<td>Intravenous or intramuscular injections and intravenous feeding. Oral medications covered only where the complexity of the medical condition (physical/psychological) and the number of drugs require a licensed nurse to monitor, detect, and evaluate side effects (this must be well-documented). rather than by mouth.</td>
<td>Injections that can be self-administered (insulin); drugs not considered an effective treatment for condition given; a medical reason does not exist for providing drug by injection</td>
</tr>
<tr>
<td>2. Vitamin B-12 Injections</td>
<td>Initially once a week for a maximum of 4-6 weeks and then once a month when maintenance is established for the treatment of pernicious anemia and other macrocytic anemias, and neuropathies associated with pernicious anemia.</td>
<td>For other conditions which are not specifically covered.</td>
</tr>
<tr>
<td>3. Decubitus and Skin Disorders</td>
<td>When specific physician orders indicate skilled care -- requiring prescribed medications and treatment. Usually Stage III (deep without necrotic tissue) and Stage IV (deep with necrotic tissue). Infected decubiti included when treatment is specifically ordered by the physician.</td>
<td>Preventative and palliative measures, decubiti are minor usually Stage I (reddened area or inflammation) or Stage II (superficial skin break and redness surrounding).</td>
</tr>
<tr>
<td>4. Colostomy, Ileostomy, Gastrostom</td>
<td>During immediate postoperative time when maintenance care and control by the patient or family is being established; includes initial teaching.</td>
<td>General maintenance care.</td>
</tr>
<tr>
<td>5. Bowel and Bladder Training</td>
<td>Teaching of skills and facts necessary to adhere to a specific formal regime.</td>
<td>General routine maintenance program or treating</td>
</tr>
<tr>
<td>SERVICE</td>
<td>NMAP COVERS:</td>
<td>NMAP DOES NOT COVER:</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>6. Urethral Catheters and Sterile Irrigations</td>
<td>Insertions and changes when active urological problems are present and/or client is unable to do physician-ordered irrigations.</td>
<td>Routine catheter maintenance care.</td>
</tr>
<tr>
<td>7. Observation and Evaluation</td>
<td>Observation and evaluation requiring the furnishing of a skilled service for an unstable condition. The client has had a recent acute episode (past 30-60 days) or there is a well-documented history of noncompliance without nursing intervention. Significant high probability that complications would arise (within 30 to 60 days) without the skilled supervision of the treatment program on an intermittent basis.</td>
<td>General needs. Absence of any clear indication that the condition is unstable.</td>
</tr>
<tr>
<td>8. Teaching and Training Activities</td>
<td>Teaching or training requiring the skills or knowledge of a nurse. Injections, irrigating of a catheter, care of ostomy, administration of medical gases, respiratory treatment, preparation and following a therapeutic diet, application of dressing to wounds involving prescription medications and aseptic techniques, bladder training, bowel training (only when bowel incontinency exists), use of adaptive devices &amp; special techniques when loss of function has occurred, care of bed-bound patient, performance of body transfer activities; requires specific documentation.</td>
<td>Visits made solely to remind or emphasize the need to follow instructions; when services are duplicated.</td>
</tr>
<tr>
<td>9. Enemas/Removal of Impactions</td>
<td>When skills of a nurse are required; if complexity is established because of the condition of the patient.</td>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>NMAP COVERS:</td>
<td>NMAP DOES NOT COVER:</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>10. Dressings</td>
<td>Aseptic technique and prescription medications used.</td>
<td>Non-infected closed postoperative wound or chronic controlled conditions (stasis ulcers).</td>
</tr>
<tr>
<td>11. Casts</td>
<td>If orders reflect other than routine care.</td>
<td>General supportive care.</td>
</tr>
<tr>
<td>12. Home Health Aides</td>
<td>Primary function of aide is for personal care which is made specific by the licensed nurse; must be under the supervision of a licensed nurse; and treatment plan established by physician indicates need.</td>
<td></td>
</tr>
<tr>
<td>13. Diabetic (Blind or Disabled)</td>
<td>Visits to prefilm insulin syringes.</td>
<td></td>
</tr>
<tr>
<td>14. Teaching &amp; Training (Postpartum)</td>
<td>Teaching and training require the skills or knowledge of a nurse. Limited to two visits, unless unusual situation is well documented.</td>
<td>Visits made solely to remind or emphasize the need to follow instructions.</td>
</tr>
<tr>
<td>15. Draw or Collect Laboratory Specimens</td>
<td>Covered only if based on the client’s medical condition. Home Health services are medically necessary and appropriate services to be provided in the home.</td>
<td>These services for nursing home clients.</td>
</tr>
</tbody>
</table>
9-002.08A Occupational Therapy, Physical Therapy, and Speech, Hearing, and Language Therapy:

9-002.08A1 Services for Individuals Age 21 and Older: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals age 21 and older as a Home Health Agency service only when the following criteria is met. The services must -

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
   a. The services must be restorative when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time;
   b. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
   c. The services must have been recommended in a Department-approved individual program plan (IPP); or
   d. The services must have been recommended in an individual education plan (IEP) or an individual family service plan (IFSP) (see 471 NAC 17-002.04).

These therapies for adults (age 21 and older) are a Home Health Agency Service only when there is no other method for the client to receive the service. Services must be prior authorized by Central Office staff. Substantiating documentation must be submitted with the claim.

9-002.08A2 Services for Individuals Age 20 and Younger: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals birth to age 20 as a Home Health Agency service when the following criteria is met. The services must -

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
   a. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
   b. The services must have been recommended in a Department-approved IPP; or
   c. The services must have been recommended in an individual education plan (IEP) or an individual family service plan (IFSP) (see 471 NAC 17-002.04).
9-002.09 Durable Medical Equipment: Durable medical equipment and medical supplies provided by a home health agency must meet all requirements outlined in 471 NAC 7-000.

9-002.10 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division of the Department of Health and Human Services Finance and Support.

9-002.11 Extended-Home Nursing Services: Provision of extended-home nursing services (RN or LPN) must be authorized by Central Office staff. These services are authorized for eligible adults or children when -

1. Night hours are necessary so the caregiver/parents may sleep;
2. Day hours to cover work/school for the caregiver/parents; and/or
3. Respite hours to cover relief time for caregiver/parents.

Extended-home nursing services are authorized only when the client's care needs must be provided by skilled nursing personnel in the absence of the caregiver/parents. Children must have documented medical needs that cannot be met by the regular child care provider system.

Any change in the client's condition or schedule of the caregiver/parents require a reevaluation of the approved nursing hours.

Written verification of the caregiver/parents' work/school schedule must be submitted initially, annually and anytime there is a change in those hours.

Nursing care hours approved specifically for sleep and/or work/school must be used as authorized, i.e., night hours, are to be used at night, work hours are to be used only when the caregiver/parents are both actually working.

Nursing hours are approved for the client when the caregiver/parent attends education classes working toward a degree. Hours are not covered for any additional degrees beyond an initial college degree.
9-002.11A Nursing Coverage at Night: Caregivers/families may be eligible for night hours if the client requires procedures on an ongoing basis throughout the night hours. Night hours will be authorized only if the monitoring and treatments cannot be accomplished during day and evening hours. The rationale for night hours is to provide caregivers/families with sleep so they can care for the client during the day. The goal must be to develop treatment and sleep patterns so the client can sleep during the night and nursing coverage will not be necessary. The medical necessity for monitoring/treatments during the night hours must be reflected in the physician's orders and nursing notes.

If a scheduled night shift is cancelled by the agency, the caregiver/family may reschedule those hours with the home health agency within the next 24 hours. When that is not possible, they may reschedule the hours within the 48 hours following the missed shift.

9-002.11B Respite: Caregivers/families who are allotted respite hours on a weekly or monthly basis can use those hours in any time configuration they determine best to meet their needs within a calendar month. If they would like to "pool" respite hours across two months, prior approval is required.

The number of respite hours approved is based on each individual situation, taking into consideration the client's and caregiver/family's needs.

9-003 Limitations and Requirements for Home Health Agency Services

9-003.01 Authorization: Payment for all home health agency services must be authorized. The eligibility of the client must be verified by the home health agency. The Division of Medicaid and Long-Term Care or its designee may grant authorization of payment for home health agency services.

Providers must send requests for authorization to the Division at the Central Office. To request authorization, the home health agency must submit Form CMS-1450 or the standard electronic Health Care Service Review – Request by Review and Response transaction (ASC 12N 278) (see 471-000-50 Electronic Transactions Instructions) and submit a copy of the physician's order and the home health agency's treatment plan. The home health agency must submit this documentation with the claim submitted for payment. The treatment plan must include:

1. The client's name, address, case number, and date of birth;
2. The dates of the period covered (not exceeding 60 days);
3. The diagnosis;
4. The type and frequency of services;
5. The equipment and supplies needed;
6. A brief, specific description of the client’s needs and services provided; and
7. Any other pertinent documentation which justifies the medical necessity of the services.

If denied, the Department notifies the provider.

Note: For durable medical equipment and medical supplies, see requirements and procedures for prior authorization outlined in 471 NAC 7-000.

9-003.02 (Reserved)

9-003.03 Student Nurses: Medicaid does not cover skilled nursing visits by student nurses who are enrolled in a school of nursing and not employed by the home health agency, unless accompanied by a registered nurse who is an employee of the home health agency.

9-003.04 Teaching and Training: The Department limits skilled nursing visits for teaching and training on an individual basis. The Department requires specific documentation for teaching and training. The client must have a medical condition which has been diagnosed and treated by a physician. There must be a physician’s order for the specific teaching and training.

The Department limits postpartum visits for teaching and training to two visits. The necessity of further visits must be justified and well documented. Court-ordered services and requests from local office staff when Adult/Child Protective Services is involved are covered services when medical necessity is documented.

9-003.05 Medical Supplies: Payment for supplies normally carried in the nursing bag and incidental to the nursing visit is included in the per visit rate. This includes but is not limited to disposable needles and syringes, disposable gloves, applicators, tongue blades, cotton swabs, 4 x 4’s, gauze, bandages, etc.

Medical supplies not normally carried in the nursing bag may be provided by pharmacies, medical suppliers, or the home health agency under requirements outlined in 471 NAC 7-000.
9-003.06  Second Visit on Same Day: The medical necessity of a second visit on the same date of service must be well documented. Substantiating documentation must be submitted with Form CMS-1450, or the request for prior authorization with the standard Health Care Claim: Institutional transaction (ASC X12N 837).

9-003.07  Enterostomal Therapy: NMAP recognizes enterostomal therapy visits as a skilled nursing service.

9-003.08  Nursing Services (RN and LPN) for Adults Age 21 and Older: NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older (this includes Nursing Services, 471 NAC 13-000):

1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.

2. Per diem reimbursement for all other in-home nursing service shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

9-003.09  Supervisory Visits: Skilled nursing visits required for the supervision of LPN or aide services may not be billed as a skilled nursing visit. The cost of supervision is included in the payment for the LPN or aide service.

9-003.10  Extended-Home Health-Tech Rates: High-tech hourly rates are approved when clients require:

1. Ventilator care;
2. Tracheostomy care which involves frequent suctioning and monitoring; and/or
3. Care/observation of unstable, complex medical conditions requiring advanced nursing knowledge/skills.

9-003.11  Advance Directives: Medicaid-participating home health agencies shall comply with these regulations (see 471 NAC 2-005).
9-004 Payment for Home Health Agency Services: The Department makes payment for medically prescribed and Department-approved home health agency services provided by home health agencies that meet Medicare certification or JCAHO accreditation. The Department may request a cost report from any participating agency.

NMAP pays for covered home health agency services at the lower of -

1. The provider’s submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service. See 471-000-57.

Note: Durable medical equipment and medical supplies are reimbursed according to the payment methodology outlined in 471 NAC 7-000.

9-004.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCs and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

9-004.02 Medicare Coverage: Medicare coverage is considered to be the primary source of payment for home health agency services for eligible individuals age 65 and older and for certain disabled beneficiaries. NMAP does not make payment for services denied by Medicare for lack of medical necessity. NMAP may cover services denied by Medicare for other reasons if the services are within the scope of NMAP. Claims submitted to the Department for services provided to Medicare-eligible clients must be accompanied by documentation which verifies that the services are not covered by Medicare.

9-004.03 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008. Home health agency services do not require a copayment from the client.

9-005 Billing Requirements: Home health agencies shall use Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) to request payment from NMAP. For claim submission instructions, refer to the Claim Submission Table in the appendix 471-000-49.

HCPCs/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-509).

Note: Durable medical equipment and medical supplies are billed under the home health agency provider number.
CHAPTER 10-000 HOSPITAL SERVICES

10-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), a hospital that provides hospital inpatient and/or outpatient/emergency room services must:

1. Be maintained primarily for the care and treatment of patients with disorders other than mental disease;
2. Be licensed as a hospital by the Nebraska Department Health and Human Services Regulation and Licensure or the officially designated authority for state standard-setting in the state where the hospital is located;
3. Have licensed and certified hospital beds; and
4. Meet the requirements for participation in Medicare and Medicaid.

10-001.01 Provider Agreement: To participate in NMAP, a hospital shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," (see 471-000-91) and submit the completed form to the Nebraska Department of Health and Human Services Finance and Support for approval and enrollment as a provider.

To continue participation in NMAP, the Medicaid Division staff must receive a copy of Form CMS-1539, "Medicare/Medicaid Certification and Transmittal" (see 471-000-66) from the Nebraska Department of Health and Human Services Regulation and Licensure, indicating that the hospital is certified.

10-001.01A Out-of-State Hospital Provider Agreement: Each out-of-state hospital shall submit the following:

1. A completed and signed Form MC-20, "Medical Assistance Hospital Provider Agreement;" and
2. The hospital's certification/accreditation status from the state survey agency in the state where the hospital is located.

The Nebraska Medical Assistance Program shall not process an out-of-state hospital's claim until all information required under this section has been received.

See 471 NAC 10-010.03H, Out-of-State Hospital Rates, and 10-010.06F, Payment to an Out-of-State Hospital for Outpatient Hospital and Emergency Room Services.

10-001.02 Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Health Connection, which is Nebraska’s Medicaid Managed Care Program. See 471-000-122 for a listing of the NHC plans.
10-001.02A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and claim submission instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 10-005.20, certain transplants such as liver, kidney, heart, and bone marrow, continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO’s capitation payment;

2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and

3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). The client must be able to obtain family planning services upon request and from any appropriate provider who is enrolled in NMAP. Family planning services are reimbursed by the HMO, regardless of whether the service is provided by a PCP enrolled with the HMO or a family planning provider outside the HMO.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP (see exceptions above). The provider shall provide services only under arrangement with the HMO.

10-001.02B Primary Care Case Management (PCCM) Plans: All NMAP policies under this chapter apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 10-005.01, the provider shall obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 10-005.20, transplants are subject to prior authorization by NMAP; and

2. Abortions: As currently defined, abortions require prior authorization by NMAP.

10-001.02B1 Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP shall authorize the services to be provided by the approved provider as needed with the following exceptions:

1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers shall contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.
2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 must bill that service on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837), using CPT procedure codes. These services require referral/authorization from the client's PCP. The provider must contact the PCP before providing these services. If a client requires hospitalization for dental treatment or for medical and surgical services billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837), the provider must contact the PCP for referral/authorization.

3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 2-006.05, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

10-001.02C Mental Health and Substance Abuse Services: Mental health and substance abuse services (MH/SA) are provided by a prepaid health plan (PHP) for all NHC clients. The PHP includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization from the PHP. All other MH/SA services must be prior authorized by the PHP as directed by the plan.

10-001.03 Definitions: The following definitions apply in this chapter.

Client: An individual who is eligible for the Nebraska Medical Assistance Program.

Diagnostic Service: An examination or procedure to which the patient is subjected or which is performed on materials obtained from the patient to provide information for the diagnosis or treatment of a disease or to assess a medical condition. This may include radiological and pathological services.

Hospital-Affiliated Ambulatory Surgical Center (HAASC): An ambulatory surgical center operated by a hospital (i.e., under common ownership, licensure, or control of a hospital). An HAASC may be covered under Medicare (and therefore under the Nebraska Medical Assistance Program) as an ASC or an HAASC. A facility operated by a hospital as a Medicare-participating ASC is paid according to 471 NAC 26-005. Other HAASC's are paid according to 471 NAC 10-010.06.

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

Hospital Inpatient Services: Medically necessary services that are furnished in a hospital for the care and treatment of an inpatient under the direction of a licensed practitioner under the scope of his/her licensure.
Hospital Outpatient Observation Services: Observation services are those services furnished by a hospital on the hospital premises, including use of a bed and periodic monitoring by a hospital’s nursing staff or other staff which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Most observation services do not exceed 1 day. Some patients may require a second day of outpatient observation services. A maximum of 48 hours of observation may be reimbursed. When a client receives hospital observation services and is thereafter admitted as an inpatient of the same hospital, the hospital observation services are included in the hospital’s payment for the inpatient services.

Hospital Outpatient Services: Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients under the direction of a physician or dentist in an institution that meets the standards for participation in 471 NAC 10-001.

When a client receives hospital outpatient/emergency room services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the hospital outpatient/emergency room services are included in the hospital's payment for the inpatient services.

Hospital outpatient services furnished in the outpatient/emergency room to a patient classified as "dead on arrival" are covered through pronouncement of death, providing the hospital considers these patients as outpatients for recordkeeping purposes and follows its usual outpatient billing practices for services to all patients. This coverage does not apply if the patient was pronounced dead before arrival at the hospital.

Inpatient: NMAP classifies a person as an inpatient when the following occurs:

1. A person has been admitted to a hospital for bed occupancy to receive hospital inpatient services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that s/he will remain at least overnight and occupy a bed even though it later develops that s/he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight;
2. The patient has been formally admitted as an inpatient and death occurs before 24 hours elapse. These services are counted as one inpatient day.
All services are subject to review for appropriateness and medical necessity of the admission and/or level of care provided as required by 471 NAC 10-010.11.

**Inpatient Days:** A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Medicaid reporting purposes, even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. The day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day. (Charges for ancillary services on the day of discharge or death or the day on which a patient begins a leave of absence are covered.) If inpatient admission and discharge or death occur on the same day, the day is considered a day of admission and counted as one inpatient day.
When a registered inpatient is occupying any other ancillary area, such as surgery or radiology, at the census-taking hour before occupying an inpatient bed, the patient's occupancy must not be recorded as an inpatient day in the ancillary area; however, the patient must be included in the inpatient census of the routine care area.

The Department utilizes the current Medicare methodology in accounting for the inpatient accommodations on the Medicare cost report.

**Emergency Medical Condition**: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, that a prudent lay person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman and her unborn child) afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person.

**Neonatal Intensive Care**: Intensive care services provided to an infant in an intensive care unit specially equipped to care for such infants.

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

**Nursery Care**: Services for a newborn child from time of birth to time of discharge of the mother from the facility. Hospitals reimbursed by per diem shall bill nursery care unless the newborn -

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

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

If a patient receives 24 hours or more of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed and whether s/he remained in the hospital past midnight or the census-taking hour.
Pathological Services: Microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or pathological examinations or procedures performed on materials obtained from the patient to provide information for the diagnosis or treatment of a disease or an assessment of the medical condition of the patient.

Patient: An individual who is receiving medically necessary services directed by a licensed practitioner, under the scope of his/her licensure, toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

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

Therapeutic Services: Services provided on an inpatient or outpatient basis which are incident to the services of the physicians in the treatment of patients.

10-001.04 Summary of Forms and Standard Electronic Transactions: The following forms and transactions are used in this chapter:

1. Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). Note: Instructions for completing Form CMS-1450 have been published in the Nebraska Uniform Billing Data Element Specifications manual published by the Nebraska Uniform Billing Committee. Providers may purchase copies from the Nebraska Association of Hospitals and Health Systems. For instructions to the electronic transaction, see claim submission table at 470-000-49;
2. Form CMS-1539, "Medicare/Medicaid Certification and Transmittal" (see 471-000-66);
3. Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91);
4. Form MMS-100, "Sterilization Consent Form" (see 471-000-109);
5. Form MMS-101, "Informed Consent Form" (see 471-000-110);
6. Form MS-6, "Ambulatory Room and Board Agreement" (see 471-000-73); and
8. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transactions Instructions at 471-000-50);

Instructions and examples appear in the appendix at the end of this title.

10-001.05 Definition of Medical Necessity: NMAP defines medical necessity as follows:

Medical Necessity: Health care services and supplies which are medically appropriate and -

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

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies that do not meet the definition of medical necessity set out above are not covered.

10-002 Covered Inpatient Services: Payment for services described in this section is included in the hospital's payment for inpatient services (see 471 NAC 10-010.03).

10-002.01 Class of Care: The Nebraska Medical Assistance Program covers the following classes of care:

1. Outpatient;
2. Acute;
3. Psychiatric (only for licensed psychiatric beds);
4. Rehabilitation (only if licensed rehabilitation beds); and
5. Nursery (Bassinet).

Beginning with dates of service October 16, 2003, level of care value codes will no longer be used to determine class of care. The provider shall use the appropriate bill type on the claim (see Claim Submission Table at 471-000-49).

10-002.02 Bed and Board: The Nebraska Medical Assistance Program pays the same amount for inpatient services whether the client has a private room, a semiprivate room (two-three- or four-bed accommodations), or ward accommodations.

10-002.03 Passes or Leaves of Absence: The day on which a client begins a pass or leave of absence may be treated as a day of discharge. Therapeutic passes will be evaluated for medical necessity and are subject to medical review or the Department's utilization review (UR) activities. The hospital is not paid for therapeutic passes or leave days. See 471 NAC 10-010.11. Note: For psychiatric services, see 471 NAC 20-000. For mental health and substance abuse services for children and adolescents, see 471 NAC 32-000.

10-002.04 Nursing Services: Nursing and other related services and use of hospital facilities for the care and treatment of inpatients are included in the hospital's payment for inpatient services.
Note: The services of a private-duty nurse or other private-duty attendant are not covered as a hospital service (see 471 NAC 13-000, Nursing Services). Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient.

10-002.05 Services of Interns and Residents-In-Training: NMAP covers the reasonable cost of the services of interns or residents-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council of Dental Education of the American Dental Association.

Note: See 471 NAC 10-010.03B6a, Calculation of Direct Medical Education Cost Payments and 471 NAC 10-010.03B6b, Calculation of Indirect Medical Education Cost Payments.

10-002.05A Approved Programs for Podiatric Interns and Residents-In-Training: The services of interns and residents-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association are covered under NMAP on the same basis as the services of other interns and residents-in-training in approved teaching programs.

10-002.06 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.03. These services must be prior authorized by the Medical Services Division of the Department of Social Services.

10-003 Ancillary Services: Payment for the ancillary services described in this section is included in the payment for inpatient services. Outpatient services must be claimed using the appropriate national standard code sets, such as HCPCs and CPT.

10-003.01 Blood Administration: Since the Medicare blood deductible applies only to blood costs, and does not apply to blood processing costs, it is necessary that hospitals distinguish between those two costs under the following rules -

1. Blood Costs: A hospital's blood costs will consist of amounts it spends to procure blood, including -
   a. The cost of activities as soliciting and paying donors and drawing blood for its own blood bank; and
   b. When a hospital purchases blood from an outside blood source (e.g., a commercial or voluntary blood bank or a blood bank operated by another hospital) an amount equal to the amount of credit which the outside blood source customarily gives the hospital if the blood is replaced.
2. **Blood Processing**: A hospital's blood processing costs consists of amounts spent to process and administer blood after it has been procured, including:
   a. The cost of such activities as storing, typing, cross-matching, and transfusing blood;
   b. The cost of spoiled or defective blood; and
   c. The portion of the outside blood source's blood fee which remains after credit is given for replacement.

   **Note**: Autologous blood donation processing costs ARE not covered for reimbursement by the NMAP.

For Medicare/Medicaid clients, NMAP covers the first three pints of blood. NMAP covers any blood administration not covered by Medicare or other third-party insurance if it is medically necessary.

### 10-003.02 Drugs

1. **Inpatient Drugs**: NMAP covers drugs for use in the hospital which are ordinarily provided by the hospital for the care and treatment of inpatients. Payment for inpatient drugs is included in the hospital's payment for inpatient services.

2. **Hospital Outpatient or Emergency Room Drugs**: NMAP covers drugs utilized in the actual treatment as part of the outpatient or emergency room service. The hospital shall bill drugs used in the outpatient or emergency room service by National Drug Code (NDC) on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). Providers must also report the quantity and unit of measure of the NDC. Include the correct NDC information on all claims, including Medicare and other third party claims.

3. **Take-Home Drugs**: NMAP covers take-home drugs under 471 NAC 16-000 only when the hospital employs a registered pharmacist and has a licensed pharmacy. Claims must be submitted via the NE-POP system or on the universal drug claim.

### 10-003.03 Medical Supplies and Equipment

**Medical Supplies**: Expendable or specified reusable supplies required for care of a medical condition and used in the client's home must be prescribed by a physician or other licensed practitioner within the scope of his/her licensure. This includes dressings, colostomy supplies, catheters, and other similar items.

**Durable Medical Equipment**: Equipment which -

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client's home.
Orthotics: Rigid or semi-rigid devices to prevent or correct physical deformity or malfunction, to support a weak or deformed part of the body, or to eliminate motion in a diseased or injured part of the body.

Prosthetic: A device which replaces a missing part of the body. NMAP does not cover external powered prosthetic devices.

10-003.03A Inpatient Supplies and Equipment: NMAP covers supplies and equipment provided to inpatients for use during the inpatient stay. These are included in the hospital's payment for inpatient services.

Certain items used during the client's inpatient stay are included in the hospital's payment for inpatient services even though they leave the hospital with the client. This includes items used in the actual treatment of the patient which are permanently or temporarily inserted in or attached to the patient's body.

10-003.03B Hospital Outpatient and Emergency Room Supplies and Equipment: NMAP covers medically necessary supplies and equipment used for outpatient and emergency room services. This includes items used in the actual treatment of the patient as well as items necessary to facilitate the patient's discharge. These services are claimed in a summary bill format on Form CMS-1450 or the standard electronic Health Care Claim: Institutional Transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49).

10-003.03C Take-Home Supplies and Equipment: NMAP may cover, for the patient's convenience upon discharge, up to a 10-day supply of take-home medical supplies.

10-003.03C1 Inpatient Services: Up to a 10-day supply of take-home supplies following an inpatient stay is an allowable cost and is included in the hospital's payment for inpatient services. The supplies must be billed on the appropriate claim or electronic format (see Claim Submission Table at 471-000-49).

10-003.03C2 Outpatient Services: Up to a 10-day supply of take-home supplies may be covered as an outpatient service. Supplies must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate revenue code.

10-003.03C3 Durable Medical Equipment: Take-home durable medical equipment, including orthotics and prosthetics, must be obtained from and billed by the appropriate provider. Exception: See 471 NAC 10-005.22 ff. regarding rental of apnea monitors and 471 NAC 10-005.22 ff. regarding rental of home phototherapy units.
10-003.04  **Personal Care Items:** NMAP covers personal care items, such as lotion, toothpaste, admit kits, etc., when they are necessary for the care of a client during inpatient or outpatient services.

10-003.05  **Radiology and Pathology:** NMAP covers medically necessary radiological and pathological services provided to inpatients and outpatients. NMAP covers only those services which are directly related to the patient's diagnosis. On claims for radiology and pathology, the provider must indicate the diagnosis which reflects the condition for which the service is performed, and if necessary, include a notation on the claim which documents the need.

**Prior Authorization of Radiology Procedures:** Effective September 1, 2009, all non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans will require prior authorization. See 471 NAC 18-004.30A. These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital’s emergency room.

10-003.05A  **Outpatient Diagnostic Services Provided by Arrangement:** NMAP covers medically necessary diagnostic services provided to an outpatient by arrangement (i.e., another hospital or independent clinical laboratory).

10-003.05A1  **Diagnostic Services Provided by an Independent Clinical Laboratory:** An independent clinical laboratory is one which is independent both of an attending or consulting physician’s office and of a hospital. A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered to be a consulting physician.

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

1. When state or applicable local law provides for licensing of independent clinical laboratories, the laboratory must be licensed under the law; and
2. The laboratory must also meet the health and safety requirements prescribed by the Secretary of Health and Human Services.

Note: A radiological laboratory is not considered an “independent laboratory” under NMAP.

10-003.05A2 Billing Cost for Diagnostic Laboratory Services Obtained by Arrangement: When a hospital obtains laboratory tests for nonpatients under arrangements with an independent laboratory or other hospital laboratory, either the originating hospital (or hospital lab) may claim all tests or the originating hospital and reference lab may claim the tests each performs. (See 471 NAC 10-010.06 for payment of hospital outpatient services and clinical laboratory services.)

Handling charges are not allowed when a specimen is referred by one laboratory to another.

10-003.05B Specimen Collection Fees: Separate charges made by laboratories for drawing or collecting specimens are allowable whether or not the specimens are referred to another hospital or laboratory for testing. This fee will be paid to the provider who extracted the specimen from the patient. Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. A specimen collection fee is allowed for activities such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from a patient who resides in a nursing facility or who is homebound. The technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization. A specimen collection fee is not allowed for a visiting technician when a patient in a facility is not confined to the facility or when the facility has personnel on duty qualified to perform the specimen collection.

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

A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal, such as a throat culture, a routine capillary puncture, or a pap smear.
10-003.05C Professional and Technical Components for Hospital Diagnostic and Therapeutic Services: Hospital diagnostic and therapeutic services are procedures performed to determine the nature and severity of an illness or injury, or procedures used to treat disease or disorders. Hospital diagnostic and therapeutic services include both hospital inpatient and outpatient services.

Hospital diagnostic and therapeutic services are comprised of two distinct elements: the professional component and the technical component. Examples of hospital services which have professional and technical components are:

1. Pathology/Laboratory:
   a. Anatomical;
   b. Clinical;
2. Radiology:
   a. Diagnostic radiology;
   b. Diagnostic ultrasound;
   c. Therapeutic radiology;
   d. Nuclear medicine;
3. Anesthesia;
4. Psychiatric services; and
5. Miscellaneous diagnostic and therapeutic services:
   a. Dialysis;
   b. Gastroenterology;
   c. Otorhinolaryngologic;
   d. Cardiovascular;
   e. Pulmonary;
   f. Allergy and clinical immunology;
   g. Neurology and neuromuscular;
   h. Chemotherapy;
   i. Dermatology;
   j. Physical medicine;
   k. Special services and reports; and
   l. Surgery.

NMAP may designate other services as having professional and technical components when the services are identified.

10-003.05D Professional Component: The professional component of hospital diagnostic and therapeutic services includes those physician's services directly related to the medical care of the individual patient (i.e., interpretation of laboratory tests, x-rays, EKG's, EEG's, etc.). A physician includes not only a specialist but also a physician who normally performs or supervises these services for all inpatients and outpatients of a hospital, even though the physician does not otherwise specialize in this field (i.e., laboratory, radiology, cardiopulmonary).

The professional component must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) or the appropriate claim for the provider, such as the American Dental Association (ADA) dental claim form except for facilities paid under an all-inclusive rate.
10-003.05D1 Coverage Conditions: To be covered as a professional component, the physician's services must -

1. Be personally provided to an individual patient by a physician;
2. Contribute directly to the diagnosis or treatment of an individual patient;
3. Ordinarily require performance by a physician;
4. Be medically necessary; and
5. For anesthesiology, laboratory, or radiology services, meet the requirements of 471 NAC 10-003.05F4, 10-003.05F5, or 10-003.05F6.

10-003.05E Technical Component: The technical component of hospital diagnostic and therapeutic services is comprised of two distinct elements -

1. Physicians' professional services not directly related to the medical care of the individual patient (i.e., teaching, supervision, administration, and other services that benefit the hospital's patients as a group); and
2. Hospital services (i.e., equipment, supplies, technicians, etc.).

The hospital shall claim the technical component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment for the technical component of inpatient services is included in the hospital's payment for inpatient services whether provided directly or under arrangement with an outside provider. The hospital is responsible for payment of all services provided to an inpatient under arrangement by an outside provider (except ambulance services, see 10-003.05F1d) to the outside provider (for inpatient services) if the service is provided under arrangement.

The technical component of outpatient and nonpatient services must be claimed by the provider actually providing the service. The Department's payment for the technical component includes payment for all non-physician services required to provide the procedure. Stat fees, specimen handling, call back, room charges, etc., are not reimbursed separately.

10-003.05E1 Non-Physician Services and Items: The elimination of combined billing requires the separation of physician services (professional component) from non-physician services (technical component) for billing purposes.

All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics, prosthetics, etc.), provided to hospital inpatients or outpatients must be billed by the hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) and must be provided directly by the hospital or under arrangements. If the services or items are provided under arrangements, the hospital is responsible for payment to the non-physician provider or supplier. The Nebraska Medical Assistance Program prohibits the "unbundling" of costs by hospitals for non-physician services or supplies provided to hospital patients, including ancillary services provided by another hospital.
All other non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics and prosthetics, etc.) provided to non-patients must be billed by the provider/supplier of the service or item on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). **Exception:** Rental of apnea monitors.

Payment for the technical component for a medically necessary service required and/or ordered by a physician must be claimed by the hospital as a hospital service on the appropriate claim form or electric format (see Claim Submission Table at 471-000-49).

**10-003.05E1a Inpatient Services:** All non-physician services, drugs, and items provided to hospital inpatients must be billed by the hospital as ancillary services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). The hospital's payment for inpatient services includes payment for all ancillary services, including:

1. Outpatient and emergency room services provided by the hospital before admission; and
2. Outpatient or inpatient services provided by another hospital or free-standing medical facility (i.e., an ambulatory surgical center (ASC)) to an inpatient of the original admitting facility.

The hospital is responsible for payment of the service to the non-physician provider or supplier.

**10-003.05E1b Outpatient Services:** All non-physician services, drugs, and items provided to hospital outpatients must be billed by the hospital as hospital outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). All non-physician services, drugs, and items provided by a non-physician provider or supplier to a hospital outpatient must be billed by the hospital as a hospital outpatient service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment for these services is made according to 471 NAC 10-010.06 ff. The hospital is responsible for payment to the non-physician provider or supplier.

All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics and prosthetics, etc.) provided in the emergency room or outpatient facility must be billed by the hospital as outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

All non-physician services, drugs, medical supplies, and items provided to non-patients must be billed by the non-physician provider or supplier on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). **Exception:** Apnea monitors (see 471 NAC 10-005.21 ff.).

The rental or sale of durable medical equipment must be billed by the supplier on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). **Exception:** Apnea monitors (see 471 NAC 10-005.21 ff.).
Inpatient Services and Fittings: Durable medical equipment, orthotics and prosthetics, fittings, etc., provided to a hospital inpatient when the item is provided while the client is an inpatient must be billed by the hospital as an ancillary service. Payment for durable medical equipment, orthotics, and prosthetics, etc., for hospital inpatients is included in the hospital's payment for inpatient services. The hospital is responsible for payment to the supplier.

Exception: In the event a customized wheelchair for primary use in other than the hospital setting is needed for training purposes while the client is a hospital inpatient, the non-hospital supplier/provider may deliver the wheelchair to the client during the inpatient stay and bill NMAP. This exception does not apply to other items provided for use in the hospital setting.

Fittings for durable medical equipment, orthotics and prosthetics, etc., provided to a hospital inpatient when the item is provided after the client is dismissed from the hospital must be billed to the Department by the non-hospital supplier/provider.

Ambulance Services: A hospital-based ambulance service is an ambulance service owned and operated by a hospital. Providers of ambulance services shall meet the licensure and certification requirements of the Nebraska Department of Health.

Covered Services: NMAP covers medically necessary and reasonable ambulance services required to transport a client to obtain or after receiving Medicaid-coverable medical care.

To be covered by NMAP, 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, NMAP shall not make payment for ambulance service. Claims for ambulance services must include adequate documentation for determination of medical necessary.
10-003.05E1d(2) Billing for Hospital-Based Ambulance Services: Hospital-based ambulance services provided to an inpatient or an outpatient must be claimed on the appropriate claim format or electronic format (see Claim Submission Table at 471-000-49) as a hospital outpatient service by the hospital-based ambulance provider. Hospital-based ambulance services are reimbursed as a hospital outpatient service (see 471 NAC 10-010.06). Hospital-based ambulance costs are not included in the calculations for hospital inpatient rates.

Charges for ambulance services provided by an independent ambulance provider, regardless of whether the patient is an inpatient or outpatient, must be submitted on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) by the ambulance provider.

10-003.05E1d(3) Ground Ambulance Services

10-003.05E1d(3)(a) Basic Life Support (BLS) Ambulance: A BLS ambulance provides transportation plus the equipment and staff needed for basic services such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, cardio-pulmonary resuscitation (CPR), defibrillation, etc.

10-003.05E1d(3)(b) Advanced Life Support (ALS) Services: An ALS ambulance provides transportation and has complex specialized life-sustaining equipment and, ordinarily, equipment for radio-telephone contact with a physician or hospital. An ALS ambulance is appropriately equipped and staffed by personnel trained and authorized to provide specialized services such as administering IV's (intravenous therapy), establishing and maintaining a patient's airway, defibrillating the heart, relieving pneumothorax conditions, and performing other advanced life support procedures or services such as cardiac (EKG) monitoring.

10-003.05E1d(3)(c) Base Rates: Ground ambulance base rates include all services, equipment and other costs, including: vehicle operating expenses, services of two attendants and other personnel, overhead charges (linens, etc.), reusable and disposable items and supplies, oxygen, pharmaceuticals, unloaded and in-town mileage, and usual waiting/standby time.

10-003.05E1d(3)(d) Mileage: "Loaded" mileage (i.e., miles traveled while the client is present in the ambulance vehicle) is covered for out-of-town ambulance transports. Out-of-town transports are defined as trips in which the final destination of the client is outside the limits of the town in which the trip originated. "Unloaded" mileage is included in the payment for the base rate.
10-003.05F1d(3)(e) **Third Attendant:** A third attendant is covered only if the circumstances of the transport requires three attendants. Payment for a third attendant **cannot** be made when the third attendant is -

1. Needed because a crew member is not qualified to provide a service (e.g., administer IV's, etc.); or
2. Staff provided by the hospital to accompany a client during transport.

The circumstances which required the third attendant must be documented on or with the claim when billing NMAP.

10-003.05F1d(3)(f) **Waiting or Standby Time:** Waiting or standby time is separately reimbursed only when "unusual circumstances" exist. The "unusual circumstances" including why the ambulance waited and where the wait took place (e.g., the client's home, hospital, nursing facility, etc.) must be documented on or with the claim when billing NMAP.

When waiting time is covered, the first one-half hour is not reimbursed. Payment for waiting time under normal circumstances is included in the payment for the base rate.

10-003.05E1d(4) **Air Ambulance:** NMAP covers medically necessary air ambulance services only when transportation by ground ambulance is contraindicated and -

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

When billing NMAP, the provider shall bill air ambulance services as a single charge which includes base rate and mileage. The number of "loaded" miles must be included on the claim.

If a determination is made that ambulance transport is medically necessary, but ground ambulance would have been appropriate, payment for the air ambulance service is limited to the amount allowable for ground transport.
10-003.05E1d(5) Limitations and Requirements for Certain Ambulance Services

10-003.05E1d(5)(a) Emergency and Non-Emergency Transports: Emergency transports are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the client's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

10-003.05E1d(5)(b) Transports to the Facility Which Meets the Needs of the Client: Ambulance services are covered to enable the client to obtain medical care in a facility or from a physician/practitioner that most appropriately meets the needs of the client, including:

1. Support from the client's community and/or family; or
2. Care from the client's own physician/practitioner or a qualified physician/practitioner and/or specialist (e.g., to establish or maintain a "medical home").

10-003.05E1d(5)(c) Transports To A Physician/Practitioner's Office, Clinic or Therapy Center: Emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered. Non-emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered when:

1. The client is bed confined before, during, and after transport; and
2. The services cannot or cannot reasonably be expected to be provided at the client's residence (including a nursing facility or ICF/MR).
10-003.05E1d(5)(d) **Round Trip Transports for Hospital Inpatients:** Ambulance services provided to a client receiving hospital inpatient services, where the client is transported to another facility for services (e.g., diagnostic testing) and the client is returned to the originating hospital for continuation of inpatient care, are not included in the payment to the hospital for inpatient services and must be billed by the hospital-based ambulance provider.

10-003.05E1d(5)(e) **Combined ALS/BLS Transports:** When a client is transferred from a BLS vehicle to an ALS ambulance, the ALS service may be billed, however only one ambulance provider may submit the claim for the service.

When the placement of ALS personnel and equipment on board a BLS vehicle qualifies the BLS vehicle as an ALS ambulance, the ALS service may be billed.

10-003.05E1d(5)(f) **Transport of More Than One Client:** When more than one client is transported during a single trip, a base rate is covered for each client transported. The number of "loaded" miles and mileage charges must be prorated among the number of clients being billed. A notation that the mileage is prorated and why must be on or with the claim when billing NMAP.

10-003.05E1d(5)(g) **Transport of Medical Teams:** Transport of a medical team (or other medical professionals) to meet a client is not separately reimbursed. If the transport of the medical team results in an ambulance transport of the client, the services are included in the base rate of the client's transport.

10-003.05E1d(5)(h) **Transport of Deceased Clients:** Ambulance services are covered if the client is pronounced dead while enroute to or upon arrival at the hospital. Ambulance services are not covered if a client is pronounced dead before the client is transported.

**10-003.05F** Billing for the Professional and Technical Components of Hospital Inpatient and Outpatient Diagnostic and Therapeutic Services: The professional component of hospital diagnostic and therapeutic services must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (or ADA dental claim form or the standard electronic Health Care Claim: Dental (ASC X12N 837 for dentists) except for facilities paid under an all-inclusive rate.

10-003.05F1 **Technical Component:** The technical component of hospital diagnostic and therapeutic services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). The technical component of hospital inpatient services must be billed as an ancillary charge. Payment is made according to 471 NAC 10-010.03 ff. The technical component of hospital outpatient services must be billed on the appropriate form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.
10-003.05F2 Professional Component: The Department requires a separate Medicaid provider number for each hospital professional component specialty. A separate provider agreement (Form MC-19) is required for each separate provider number. The professional component must be billed on Form CMS-1500, or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate provider number for the professional component of the appropriate specialty.

A hospital may act as the billing agent for the physician's professional component.

Only one specialty (one provider number) may be billed on each Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F3 Pre-Admission Testing: Payment for pre-admission testing as an ancillary service is included in the hospital's payment for inpatient services. Diagnostic services rendered up to three days before the day of admission are included in the inpatient hospital payment.

NMAP does not cover pre-admission testing performed in a physician's office or as an outpatient which is performed solely to meet hospital pre-admission requirements.

10-003.05F4 Anesthesiology

10-003.05F4a Professional Component: The Department covers, as a physician's service, the professional component of anesthesiology services provided by a physician to an individual patient if the conditions in 471 NAC 10-003.05D1 are met. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Claims for these services must indicate actual time in one-minute increments.

Note: Rural hospitals that have been exempted by their Medicare fiscal intermediary for certified registered nurse anesthetist (CRNA) billing shall follow the Medicare billing requirements.

10-003.05F4b Medical Direction of Four or Fewer Concurrent Procedures: The professional component for the physician's personal medical direction of concurrent anesthesiology services provided by qualified anesthetists, such as certified registered nurse anesthetists (CRNA's), is covered as a physician's service when the services meet the requirements listed in 471 NAC 10-003.05D1 and the following additional requirements:

1. For each patient, the physician -
   a. Performs and documents a pre-anesthetic examination and evaluation;
   b. Prescribes the anesthesia plan;
   c. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
d. Ensures that any procedures in the anesthesia plan that s/he does not perform are performed by a qualified individual;

e. Monitors the course of anesthesia administration at frequent intervals;

g. Provides indicated post-anesthesia care; and

2. The physician directs no more than four anesthesia procedures concurrently, and does not provide any other services while directing the concurrent procedures (see 471 NAC 10-003.05F4b(1)); and

3. The physician certifies on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) that s/he directed services to no more than four patients concurrently.

Claims for these services must indicate actual time in one-minute increments.

Claims for the physician's medical direction of four or fewer concurrent services provided by qualified anesthetists not employed by the physician must indicate actual time in one-minute increments.

The physician's medical direction of four or fewer concurrent anesthesia procedures is considered a professional component and must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

Claims for anesthesia services for hospital inpatients or outpatients provided by anesthetists who are not employees of a physician must be billed as a technical component as follows:

1. Inpatient services must be billed as an ancillary service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.03 ff.

2. Outpatient services must be billed using the appropriate revenue code for hospital outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.
Other Services Provided While Directing Concurrent Procedures: A physician who is directing concurrent anesthesia services for four or fewer surgical patients must not ordinarily be involved in providing additional services to other patients. The following situations are examples of services that do not constitute a separate service for determining medical direction in item 2 of 471 NAC 10-003.05F4b:

1. Addressing an emergency of short duration in the immediate area;
2. Administering an epidural or caudal anesthetic to ease labor pain;
3. Periodic, rather than continuous, monitoring of an obstetrical patient;
4. Receiving patients entering the operating suite for the next surgery;
5. Checking or discharging patients in the recovery room; or

If the physician leaves the immediate area of the operating suite for longer than short durations, devotes extensive time to an emergency case, or is otherwise not available to respond to the immediate needs of surgical patients, the physician's services to the surgical patient are supervisory in nature and are considered a technical component; therefore, these services must be billed as the technical component by the hospital. The technical component of hospital inpatient services must be billed as an ancillary service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.03 ff. The technical component of hospital outpatient services must be billed using the appropriate revenue code for hospital outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

Supervision of More Than Four Concurrent Procedures: If the physician is involved in providing direction for more than four concurrent procedures or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are covered as the technical component of the hospital services. The technical component must be billed as described in 471 NAC 10-003.05F1. The physician shall ensure that a qualified individual performs any procedure in which the physician does not personally participate. The professional component of personal services up to and including induction is covered as a physician's service and must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).
10-003.05F4d Standby Anesthesia Services: A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs and ready to furnish anesthesia services to a specific patient who is known to be in potential need of services. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F4e Claims for Payment: The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The technical component must be billed as described in 471 NAC 10-003.05F1.

10-003.05F4f Anesthesiology: The hospital may engage the services of a nurse anesthetist (either on a salary or fee-for-service basis) under arrangements which provide for billing to be made by the hospital. Reimbursement for the service when provided to an inpatient or outpatient is included in the payment rate under NMAP (see 471 NAC 10-010.03 and 10-010.06).

10-003.05F5 Laboratory/Pathology

10-003.05F5a Professional Component: The Department covers as a physician's service the professional component of laboratory services provided by a physician to an individual patient only if the services meet the requirements listed in 471 NAC 10-003.05D1 and are -

1. Anatomical pathology services;
2. Consultative pathology services, which must -
   a. Be requested by the patient's attending physician;
   b. Relate to a test result that lies outside the clinically significant normal or expected range in view of the patient's condition;
   c. Result in a written narrative report included in the patient's medical record; and
   d. Require the exercise of medical judgment by the consulting physician; or
3. Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).
Clinical Lab Services: Clinical laboratory services provided to hospital inpatients, outpatients, and non-patients are routinely performed by non-physicians (i.e., medical technologists or laboratory technicians) manually or using automated laboratory equipment. These clinical laboratory services do not require performance by a physician and are considered a technical component; there is no professional component for these services. The technical component must be billed as described in 471 NAC 10-003.05F1. Payment is made to the hospital as follows:

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

2. **Outpatient Services:** Payment is made at the fee schedule determined by CMS (see 471-000-520); Note: Outpatient clinical laboratory services must be itemized on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure codes (see 471 NAC 10-010.06).

3. **Non-Patient Services:** Payment is made at the fee schedule determined by CMS. (See 471-000-520)

Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.03B1b, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

There is no separate payment made to the pathologist for routine clinical lab services. To be paid, the pathologist must negotiate with the hospital to arrange a salary/compensation agreement.

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

Anatomical Pathology Services: Anatomical pathology services are services which ordinarily require a physician's interpretation. If these services are provided to hospital inpatients or outpatients, the professional and technical components must be separately identified for billing and payment.
10-003.05F5e Billing and Payment for Hospital Inpatient Anatomical Pathology Services: Payment for the technical component of anatomical pathology is included in the hospital's payment for inpatient services which is claimed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as an ancillary service. The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate.

The pathologist shall claim the professional component of anatomical pathology on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code and a "26" modifier. This service is paid according to the Nebraska Medicaid Practitioner Fee Schedule.

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

10-003.05F5f Billing and Payment for Hospital Outpatient Anatomical Pathology Services: The hospital shall bill the technical component of outpatient anatomical pathology services in a summary bill format using the appropriate revenue code on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The pathologist shall claim the professional component on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code and a "26" modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

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

10-003.05F5g Billing and Payment for Non-Patient Anatomical Pathology Services: For specimens from non-patients referred to the hospital, the hospital shall bill the total service (both professional and technical components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate revenue code. Payment is made according to 471 NAC 10-010.06 ff.
10-003.05F5h  Leased Departments: If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist must claim the total service (professional and technical components) on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

Leased department status has no bearing on billing for or payment for hospital inpatient or outpatient anatomical pathology services.

10-003.05F6  Radiology: All radiology services have a technical component and a professional component (physician interpretation). The professional and technical component of hospital services must be separately identified for billing and payment.

10-003.05F6a  Professional Component: The professional component of radiology services provided by a physician to an individual patient is covered as a physician's service when the services meet the requirements listed in 471 NAC 10-003.05D1 and the services are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F6b  Technical Component: The technical component of hospital radiology services, such as administrative or supervisory services or services needed to produce the x-ray films or other items that are interpreted by the radiologist, must be billed as described in 471 NAC 10-003.05F1.

10-003.05F6c  Billing and Payment for Hospital Inpatient Radiology Services: Payment for the technical component of inpatient radiology services is included in the hospital's payment for inpatient services. These costs may be included on the hospital's cost report to be considered in calculating the hospital's payment rate.

Physicians must claim the professional component of inpatient radiology services on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code with a "26" modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.
10-003.05F6d  Billing and Payment for Hospital Outpatient Radiology Services: The hospital must claim the technical component of outpatient radiology services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The physician must claim the professional component on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code with a "26" modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

10-003.05F6e  Billing and Payment for Non-Patient Radiology Services: A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. If a radiology procedure is performed for a non-patient, the hospital must claim the total component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

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

10-003.05G  Computerized Tomography (CT) Scans: NMAP covers diagnostic examinations of the head (head scans) and of certain other parts of the body (body scans) performed by computerized tomography (CT) scanners when -

1. Medical and scientific literature and opinion support the use of a scan for the condition;
2. The scan is reasonable and necessary for the individual patient; and
3. The scan is performed on a model of CT equipment that meets Medicare's criteria for coverage.

10-003.05H  Radiology and Pathology for Annual Physical Exams for Clients Residing in Nursing Facilities and ICF/MR's: The Nebraska Department of Health requires that all long term care facility residents have an annual physical examination. The physician, based on his/her authority to prescribe continued treatment, determines the extent of the examination for NMAP clients based on medical necessity. For the annual physical exam, a CBC and urinalysis will not be considered "routine" and will be reimbursed based on the physician's orders. The results of the examination must be recorded in the client's medical record.

NMAP does not cover routine laboratory and radiology services which are not directly related to the patient's diagnosis and treatment. In order to be reimbursed for a CBC and urinalysis, the hospital must note on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) that these services were performed for an annual physical exam for a nursing home client.
10-003.05J Mammograms: NMAP covers diagnostic and screening mammograms.

1. Screening Mammography: Screening mammograms are a preventive radiology procedure performed for early detection of breast cancer. NMAP covers one screening mammogram annually according to the periodicity schedule and guidelines of the American Cancer Society.

2. Diagnostic Mammography: Diagnostic mammograms are covered based on the medical necessity of the service (see 10-001.04, Medical Necessity).

Mammography services are covered only for providers who have met Medicare certification criteria for mammography services.

10-003.06 Therapeutic Services: Therapeutic services (physical, respiratory, occupational, speech, or psychological) which a hospital provides to an inpatient or outpatient are those services (including the use of the hospital facilities) which are incidental to the services of the physicians in the treatment of patients.

Covered therapeutic services to hospital inpatients/outpatients include the services of therapists and equipment necessary for therapeutic services.

10-003.07 Labor and Delivery: NMAP covers reasonable and necessary services associated with pregnancy. Medical care for pregnancy is reimbursable, beginning with diagnosis of the condition, continuing through delivery, and ending after the necessary postnatal care, or termination of pregnancy. After the infant is delivered, the infant is treated as a separate patient for reimbursement purposes.

NMAP covers routine prenatal care, delivery, six weeks post-partum care, and routine urinalysis as a package service for physicians. NMAP does not reimburse hospitals for any physicians' services included in the package service.

NMAP may cover hospital outpatient/emergency room services which meet the coverage criteria for medically necessary services which are not included in the physicians' package service.

If the patient is admitted as a registered inpatient with the expectation of remaining overnight, experiences false labor, and is released the same day before the census-taking hour, a day of inpatient maternity routine care is counted. If the patient is not admitted as an inpatient and receives care for less than 24 hours, the services are considered outpatient services. If the patient receives care for 24 or more continuous hours, the services are considered inpatient services regardless of the hour of admission or whether she remained in the hospital past midnight or the census-taking hour.

The Department utilizes the current Medicare methodology in accounting for labor/delivery charges on the Medicare cost report.
10-003.08 Operating Room: When a patient with a known diagnosis enters a hospital for a specific surgical procedure or other treatment that is expected to keep him/her in the hospital for less than 24 hours, and this expectation is realized, s/he will be considered an outpatient regardless of: the hour of admission; whether or not s/he used a bed; and whether or not s/he remained in the hospital past midnight. If the patient receives 24 or more hours of care, the patient is considered an inpatient regardless of the hour of admission or whether s/he remained in the hospital past midnight or the census-taking hour.

10-003.09 Other Ancillary Services

10-003.09A Emergency Room Physicians’ Services: The hospital shall bill the Department for emergency room physicians’ services on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the physician's provider number.

10-003.09B Medical Social Services: Medical social services are those social services which contribute meaningfully to the treatment of a patient's condition. These services include, but are not limited to:

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

The cost of medical social services when provided to an inpatient is included in the hospital's payment for the inpatient service.

10-003.09C Dialysis Services: Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis procedures in common usage: hemodialysis and peritoneal dialysis. Both are acceptable modes for treatment of end stage renal disease.

10-003.09C1 Inpatient Dialysis Services: Dialysis services provided to an individual who is an inpatient are considered to be inpatient services. Payment for inpatient dialysis services is included in the hospital's payment for inpatient services. The hospital may include the costs of inpatient dialysis services on its cost report to be considered in calculating the hospital's payment rate.

10-003.09C2 Outpatient Dialysis Services: Outpatient dialysis services are those dialysis services provided to an individual who is an outpatient. Outpatient dialysis services must be provided by a Medicare certified renal dialysis facility. Outpatient dialysis services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Outpatient dialysis services are reimbursed at the provider's current Medicare composite rate for the services provided. Payment excludes the cost of physician services.
10-004 Non-Covered Services

10-004.01 Surgical Procedures: NMAP does not cover:

1. Acupuncture;
2. Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
3. Angiocardiography, utilizing CO₂ method, supervision and interpretation only;
4. Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
5. Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
6. Ballistocardiogram;
7. Basal metabolic rate (BMR);
8. Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
9. Circumcision, female;
10. Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
11. Extra-intra cranial arterial bypass for stroke;
12. Fabric wrapping of abdominal aneurysm;
13. Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
14. Fascia lata by stripper when used as a treatment for lower back pain;
15. Hypogastric or presacral neurectomy (independent procedure);
16. Hysterotomy, non-obstetrical, vaginal;
17. Icterus index;
18. Ileal bypass or any other intestinal surgery for the treatment of obesity;
19. Kidney decapsulation, unilateral and bilateral;
20. Ligature of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;
21. Ligature of internal mammary arteries, unilateral or bilateral;
22. Ligation of thyroid arteries (independent procedure);
23. Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;
24. Omentopexy for establishing collateral circulation in portal obstruction;
25. Perirenal insufflation;
26. Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
27. Protein bound iodine (PBI);
28. Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
29. Refractive keratoplasty (includes keratomileusis, keratophakia, and radial keratotomy);
30. Reversal of tubal ligation or vasectomy;
31. Sex change procedures;  
32. Splanchnectomy, unilateral or bilateral, when used as a treatment for hypertension;  
33. Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both;  
34. Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension; and  
35. Uterine suspension, with or without presacral sympathectomy.

10-004.02 Obsolete Tests: NMAP does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:

1. Amylase, blood isoenzymes, electrophoretic;  
2. Chromium, blood;  
3. Guanase, blood;  
4. Zinc sulphate turbidity, blood;  
5. Skin test, cat scratch fever;  
6. Skin test, lymphopathia venereum;  
7. Circulation time, one test;  
8. Cephalin flocculation;  
9. Congo red, blood;  
10. Hormones, adrenocorticotropin quantitative animal tests;  
11. Hormones, adrenocorticotropin quantitative bioassay;  
12. Thymol turbidity, blood;  
13. Skin test, actinomycosis;  
14. Skin test, brucellosis;  
15. Skin test, leptospirosis;  
16. Skin test, psittacosis;  
17. Skin test, trichinosis;  
18. Calcium, feces, 24-hour quantitative;  
19. Starch; feces, screening;  
20. Chymotrypsin, duodenal contents;  
21. Gastric analysis pepsin;  
22. Gastric analysis, tubeless;  
23. Calcium saturation clotting time;  
24. Capillary fragility test (Rumpel-Leede);  
25. Colloidal gold;  
26. Bendien’s test for cancer and tuberculosis;  
27. Bolen’s test for cancer; and  

These tests may be covered only if the physician who performs the test justifies the medical necessity for the test. Medicaid Division staff shall determine that satisfactory medical necessity exists from the physician’s justification.
10-004.03 Services Required to Treat Complications or Conditions Resulting from Non-Covered Services: The Department may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

Hospital inpatient or outpatient services are sometimes required to treat a condition that arises from services which NMAP does not cover. Payment may be made for services furnished under these circumstances if they are reasonable and necessary and meet coverage criteria for the service in all other respects.

Examples of services that may be covered under this policy include, but are not limited to -

1. Complications/conditions occurring following cosmetic/reconstructive surgery not previously authorized by NMAP (for example, breast augmentation, liposuction);
2. Complications from a non-covered medical transplant or a transplant that has not been previously authorized by NMAP;
3. Complications/conditions occurring following an abortion not previously authorized by NMAP; or
4. Complications/conditions occurring following ear piercing.

If the services in question are determined to be part of a previous non-covered service, e.g., an extension or a periodic segment of a non-covered service or follow-up care associated with it, the subsequent services will be denied. For example, when a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's prognosis, these visits are not covered.

10-004.04 Services Not Reasonable and Necessary: NMAP does not cover items and services which are not reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the function of a malformed body member.

10-004.05 Experimental and Investigational Services: Experimental or Investigational Services: NMAP does not cover medical services which are considered investigational and/or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, NMAP prohibits payment for these services.

Within this part, medical services include, but are not limited to, medical, surgical, diagnostic, mental health, substance abuse, or other health care technologies, supplies, treatments, procedures, drugs, therapies, and devices.

10-004.05A Related Services: NMAP does not pay for associated or adjunctive services that are directly related to non-covered experimental/investigational services (for example, laboratory services, radiological services, other diagnostic or treatment services, practitioner services, hospital services, etc.).

NMAP may cover complications of non-covered services once the non-covered service is completed (see 471 NAC 10-004.03).
10-004.05B Requests for NMAP Coverage: Requests for NMAP coverage for new services or those which may be considered experimental or investigational must be submitted before providing the services, or in the case of true medical emergencies, before submitting a claim. Requests for NMAP determinations for such coverage must be submitted in writing to the Department's Medical Director at the following address by mail or fax method:

Medical Director  
Nebraska Department of Health and Human Services  
Finance and Support  
P.O. Box 95026  
Lincoln, NE  68509-5026  
Fax Phone Number: (402) 471-9092

The request for coverage must include sufficient information to document that the new service is not considered investigational/experimental for Medicaid payment purposes. Reliable evidence must be submitted identifying the status with regard to the criteria below, cost-benefit data, short and long term outcome data, patient selection criteria that is both disease/condition specific and age specific, information outlining under what circumstances the service is considered the accepted standard of care, and any other information that would be helpful to the Department in deciding coverage issues. Additional information may be requested by the Medical Director.

Services are deemed investigational/experimental by the Medical Director, who may convene ad hoc advisory groups of experts to review requests for coverage. A service is deemed investigational/experimental if it meets any one of the following criteria:

1. There is no Food and Drug Administration (FDA) or other governmental/regulatory approval given, when appropriate, for general marketing to the public for the proposed use;
2. Reliable evidence does not permit a conclusion based on consensus that the service is a generally accepted standard of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease/proposed use and age group. Also, facility specific data, including short and long term outcomes, must be submitted to the Department;
3. The service is available only through an Institutional Review Board (IRB) research protocol for the proposed use or subject to such an IRB process; or
4. The service is the subject of an ongoing clinical trial(s) that meets the definition of a Phase I, Phase II, or Phase III Clinical Trial, regardless of whether the trial is actually subject to FDA oversight and regardless of whether an IRB process/protocol is required at any one particular institution.
**10-004.05C Definition of Clinical Trials:** For services not subject to FDA approval, the following definitions apply:

**Phase I:** Initial introduction of an investigational service into humans.

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

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

**10-004.06 Autopsies:** Autopsies are a non-covered service under Medicaid.

**10-004.07 Custodial or Respite Care:** Medicaid does not cover hospital services that are custodial or respite care.

**10-004.08 Facility Based Physician Clinics:** Physician Clinic services provided in a hospital location or a facility under the hospital’s licensure are considered content of the physician service, not outpatient hospital services. Physician clinic services are defined as the professional activity, any drugs and supplies used during that professional encounter and any other billable service provided in the physician clinic area.

1. Nebraska Medicaid does not recognize facility/hospital based non-emergency physician clinics for billing, reimbursement or cost reporting purposes except for itinerant physicians as defined in 471 NAC 18-004.41/10-005.21.

2. Services and supplies incident to a physician’s professional service provided during a specific encounter are covered and reimbursed as physician clinic services if the service or supply is:
   a. Of the type commonly furnished in a physician’s office;
   b. Furnished as an incidental, although integral, part of the physician professional services; and
   c. Furnished under the direct personal supervision of the physician.

3. The Physician’s clinic services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

**10-004.09 Tobacco Cessation Services:** Tobacco cessation services are not covered as a hospital service. Please see 471 NAC 16-000, Pharmacy Services and 471 NAC 18-000, Physicians' Services for coverage information.

**10-004.10 Hospital Acquired Conditions:** Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that Medicaid will, at a minimum, identify as an HAC, those diagnoses codes that have been identified as Medicare HACs when not present on hospital admission.
10-004.11 Health Care-Acquired Conditions: A health care-acquired condition (HCAC) means a condition occurring in any inpatient hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients.
10-005 Limitations and Requirements for Certain Services

10-005.01 Prior Authorization: NMAP requires that physicians request prior authorization from the Division of Medicaid and Long-Term Care before providing:

1. Medical transplants as follows:
   a. Heart transplants;
   b. Kidney transplants;
   c. Bone marrow transplants (allogenic and autologous); and
   d. Liver transplants;
2. Abortions;
3. Cosmetic and reconstructive surgery;
4. Gastric bypass surgery for obesity which includes the following procedures:
   a. Gastric bypass;
   b. Gastric stapling; and
   c. Vertical banded gastroplasty;
5. Out-of-State Services. Exception: Prior authorization is not required for emergency services;
6. Established procedures of questionable current usefulness;
7. Procedures which tend to be redundant when performed in combination with other procedures;
8. New procedures of unproven value;
9. Certain drug products, as specified in 471 NAC 10-005.01D; and
10. All non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans. See 471 NAC 18-004.30A.
10-005.01A Prior Authorization Procedures: The physician must request prior authorization for these services in writing or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50) prior to providing the service. See 471 NAC 10-001.02B1 for prior authorization/referral management for NMMCP.

10-005.01A1 Request for Additional Evaluations: NMAP must request additional evaluations when the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

10-005.01A2 Prior Authorization Approval/Denial Process: The prior authorization request review and determination must be completed by one or all of the following Department representatives:

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

10-005.01A3 Notification Process: Upon determination of approval or denial, the Department must send a written response to the following as applicable to the request:

1. Physician(s) submitting or contributing to the request;
2. Caseworker; and
3. Medical Review Organization when appropriate.

10-005.01B Verbal Authorization Procedures: NMAP may issue a verbal authorization when circumstances are of an emergency nature or urgent to the extent that a delay would place the client at risk of receiving medical care. When a verbal authorization is granted, a written request or electronic request using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) must be submitted within 14 days of the verbal authorization. A written or electronic response from the Department will be issued upon completion of the review.

10-005.01C Billing and Payment Requirements: Claims submitted to NMAP for services defined as requiring prior authorization will not be paid without written or electronic approval from the Department. A copy of the approval letter or notification of authorization issued by the Department must be submitted with all claims related to the procedure or service authorized.

Note: For dental services provided in a hospital (inpatient or outpatient), the dentist must request prior authorization of payment for the dental procedure from the Division of Medicaid and Long-Term Care (also see 471 NAC 6-000). Hospital outpatient services for dental procedures must be prior authorized by the Division of Medicaid and Long-Term Care.
10-005.01D Drug Products that Require Prior Approval: The following prescribed products require prior approval:

1. Sunscreens (Examples: Presun 29, Solbar-50);
2. Certain modified versions, combinations, double-strength entities, or products considered by the Department to be equivalent to drug products contained on the state maximum allowable cost or federal upper limit listings (Examples: Libritabs, Keftabs);
3. Human Growth Hormone;
4. Erythropoietin (Examples: Epogen, Procrit);
5. Drugs or supplies intended for convenience use (Examples: Refresh Ophthalmic 0.3 ml; Novolin penfil insulin);
6. Drugs used for prevention of infection with respiratory syncytial virus (e.g., respiratory syncytial virus immune globulin, palivizumab);
7. Certain drugs or classes of drugs used for gastrointestinal disorders, including but not limited to hyperacidity, gastroesophageal reflux disease, ulcers, or dyspepsia (examples: omeprazole, famotidine);
8. Certain drugs or classes of drugs used for relief of pain, discomfort associated with musculoskeletal conditions, inflammation or fever (examples: butorphanol, carisoprodol, tramadol);
9. Certain drugs or classes of drugs used for relief of cough and/or symptoms of the common cold, influenza, or allergic conditions (examples: loratadine, zanimivir, oseltamivir);
10. Certain drugs or classes of drugs that are used for non-covered services or indications (see 471 NAC 16-003 Non-Covered Services) and for covered services or indications (example: orlistat, sildenafil);
11. Certain drugs or classes of drugs on the state maximum allowable cost or federal upper limit listings;
12. Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins;
13. Certain drugs or classes of drugs that are used for tobacco cessation; and
14. Certain drugs or classes of drugs that are determined by the Pharmaceutical and Therapeutics Committee to not be placed onto the Preferred Drug List.

Identifiable products requiring approval prior to payment are designated as such on the NE-POP System or on the Department’s website.

The Department requires that authorization be granted prior to payment for certain drugs or items. Physicians who are prescribing these drugs or pharmacists who are dispensing these drugs must obtain prior authorization by submitting the request either by standard electronic transaction or by phone, fax, or mail from either:
1. The Department’s NE-POP contractor; or
2. The Pharmacy Consultant (or designee)

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
P. O. Box 95026
301 Centennial Mall South, 5th Floor
Lincoln, NE  68509
Phone:  (877) 255-3092
Fax: 402-471-9092
E-Fax: (402) 742-2348
10-005.02 Hospital Admission Diagnostic Procedures: The major factors which are considered to determine that a diagnostic procedure performed as part of the admitting procedure to a hospital is reasonable and medically necessary are:

1. The test is specifically ordered by the admitting physician, or a hospital staff physician responsible for the patient when there is no admitting physician (i.e., the test is not provided on the standing orders of a physician for all his/her patients);
2. The test is medically necessary for the diagnosis or treatment of the individual patient's condition;
3. The test does not unnecessarily duplicate the same test performed on an outpatient basis before admission or performed in connection with a recent hospital admission.

10-005.03 HIV Testing for Acquired Immune Deficiency Syndrome: NMAP payment for HIV testing is limited to medical necessity. Medical necessity for HIV testing exists if the individual has a known risk for exposure to HIV defined as follows:

1. All men who have engaged in unprotected sexual risk behaviors with another man since 1977;
2. Persons sharing contaminated hypodermic needles for intravenous drug use or other purposes since 1977;
3. Persons who have received blood or blood products between 1977-1985, especially persons with hemophilia (excluding at this time all immune serum globulin and heat-tested products, and Hepatitis B vaccine);
4. Persons who have exchanged sex for drugs or money since 1977;
5. Persons who have engaged in unprotected risk behaviors with someone who has AIDS or a known HIV-related condition or infection, or who is at increased risk or exposure to HIV:
6. Infants born to mothers infected with HIV; and
7. Persons who have engaged in unprotected sexual risk behaviors with multiple partners.

10-005.03A Non-Covered HIV Testing: NMAP does not pay for HIV testing when there is no history of risk as defined in 471 NAC 10-005.03. This includes, but is not limited to, the following:

1. Routine prenatal screening;
2. Routine pre-operative testing;
3. Educational or employment requirements;
4. Entrance requirements for the armed services; and
5. Insurance applications.

10-005.03B Informed Consent For HIV Testing (Reserved)
10-005.04 Minor Surgical Procedures: Reimbursement for excision of lesions of the skin or subcutaneous tissues include all services and supplies necessary to provide the service. NMAP does not make additional reimbursement for suture removal to the physician who performed the initial service or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the physician who provided the initial service, NMAP may approve separate payment for the suture removal.

10-005.05 Treatment for Obesity: NMAP will not make payment for services provided when the sole diagnosis is "obesity".

Obesity itself cannot be considered an illness. The immediate cause is a caloric intake which is persistently higher than caloric output. When obesity is the only diagnosis, treatment cannot be considered reasonable and necessary for the diagnosis or treatment of an illness or injury.

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

10-005.05A Intestinal By-Pass Surgery: The safety of intestinal by-pass surgery for the treatment of obesity has not been demonstrated. Severe adverse reactions such as steatorrhea, electrolyte depletion, liver failure, arthralgia, hypoplasia of bone marrow, and avitaminosis have sometimes occurred as a result of this procedure. NMAP does not consider this procedure to be reasonable and necessary, and does not cover the procedure.

10-005.05B Gastric By-Pass Surgery for Obesity: Gastric by-pass surgery for patients with extreme obesity may be covered when the surgery is -

1. Medically appropriate for the individual; and
2. Performed to correct an illness which caused the obesity or was aggravated by the obesity.

Physicians shall request prior authorization for gastric by-pass surgery prior to providing the service.

If approved, the provider shall submit a copy of the letter of authorization or notification of authorization with all claims for the service submitted to the Department.
10-005.06 Cosmetic and Reconstructive Surgery: NMAP covers cosmetic and reconstructive surgical procedures and medical services when medically necessary for the purpose of correcting the following conditions:

1. Limitations in movement of a body part caused by trauma or congenital conditions;
2. Disfiguring or painful scars in areas that are visible;
3. Congenital birth anomalies;
4. Post-mastectomy breast reconstruction; and
5. Other procedures determined to be restorative or necessary to correct a medical condition.

10-005.06A Exceptions: To determine the medical necessity of the condition, NMAP requires prior authorization for cosmetic and reconstructive surgical procedures except for the following conditions:

1. Cleft lip and cleft palate;
2. Post-mastectomy breast reconstruction;
3. Congenital hemangioma's of the face; and
4. Nevus (mole) removals.

The surgeon who will be performing the cosmetic or reconstructive (C/R) surgery shall submit a written request or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50) for prior authorization before providing the service.

If approved, the provider shall submit a copy of the letter of authorization or notification of authorization with all claims for the service submitted to the Department.

10-005.07 Sterilizations

10-005.07A Age Requirement: The Nebraska Medical Assistance Program is prohibited from paying for sterilization of individuals -

1. Under the age of 21 on the date the client signs Form MMS-100; or
2. Legally incapable of consenting to sterilization.

10-005.07B Coverage Conditions: NMAP covers sterilizations only when -

1. The sterilization is performed because the client receiving the service made a voluntary request for services;
2. The client is advised at the outset and before the request or receipt of his/her consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized;
3. Clients whose primary language is other than English must be provided with the required elements for informed consent in their primary language.
10-005.07C  Procedure for Obtaining Services: Non-therapeutic sterilizations are covered by NMAP only when -

1. Legally effective informed consent is obtained on Form MMS-100, "Consent Form" (see 471-000-109) from the client on whom the sterilization is to be performed. The surgeon shall submit a properly completed and legible Form MMS-100 to the Department before payment of claims can be considered; and

2. The sterilization is performed at least 30 days following the date informed consent was given. To calculate this time period, day 1 is the first day following the date on which the form is signed by the client. Day 31 in this period is the first day on which the procedure could be covered by NMAP. The consent is effective for 180 days from the date Form MMS-100 is signed. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since s/he signed the informed consent for the sterilization. For a premature delivery, the client must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MMS-100.

10-005.07D  Informed Consent: Informed consent means the voluntary, knowing assent of the client who is to be sterilized after s/he has been given the following information:

1. A clear explanation of the procedures to be followed;
2. A description of the attendant discomforts and risks;
3. A description of the benefits to be expected;
4. Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;
5. An offer to answer any questions concerning the procedures; and
6. An instruction that the individual is free to withhold or withdraw his/her consent to the sterilization at any time before the sterilization without prejudicing his/her future care and without loss of other project or program benefits to which the client might otherwise be entitled.

This information is shown on Form MMS-100, which must be completed by the client.

10-005.07E  Sterilization Consent Forms: Form MMS-100, "Sterilization Consent Form," (see 471-000-109) may be ordered by the physician directly from the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, or from the local HHS office. The surgeon shall submit a properly completed and legible Form MMS-100 to the Department before payment of claims can be considered.
10-005.08 Hysterectomies: NMAP covers hysterectomies when medically necessary. For payment of claims for hysterectomies (hospital, surgeon, assistant surgeon, anesthesiologist), the surgeon shall submit to the Department Form MMS-101, "Informed Consent Form," (see 471-000-110) properly signed and dated by the client in which she states that she was informed before the surgery was performed that this surgical procedure results in permanent sterility before claims associated with the hysterectomy can be considered.

Exception: NMAP does not require informed consent if -

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

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

10-005.08A Non-Covered Hysterectomies: NMAP shall not cover a hysterectomy if -

1. It was performed solely to make the woman sterile; or
2. If there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.
10-005.09 Abortions: NMAP covers medical procedures and abortions only when the life of the mother would be endangered if the fetus were carried to term. A physician shall certify the diagnosis by medical reports which include the name and address of the client. The treating physician shall request and receive prior authorization before providing the service from -

Medical Director
Medicaid Division
Nebraska Department of Health and Human Services
Finance and Support
301 Centennial Mall South, Fifth Floor
P.O. Box 95026
Lincoln, NE  68509

If approved, the Department sends a letter of authorization to the provider and retains one copy of the letter of authorization. In cases of documented emergencies, authorization may be requested after the service has been provided. All other requirements of this subsection must be met.

10-005.09A Required Forms: The provider shall submit a copy of the notification of authorization with all claims (surgeon, assistant surgeon, anesthesiologist, hospital) submitted for abortions to the Department.

10-005.10 Infertility: NMAP limits coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical problem, for example, thyroid disease, brain tumor, or hormone dysfunction. Reimbursement/coverage is not available when the sole purpose of the service is achieving a pregnancy.

10-005.11 (Reserved)
10-005.12 Alcohol and Chemical Detoxification: The Department limits payment for alcohol and chemical detoxification to medically necessary treatment, subject to the Department's utilization review.

This period includes an average detoxification period of two to three days with an occasional need for up to five days when the patient's condition dictates. A detoxification program for a particular patient may exceed five days and be covered if determined medically necessary by NMAP. The Department does not cover services when the detoxification needs of an individual no longer require an inpatient hospital setting.

10-005.13 Osteogenic Stimulation: Electrical stimulation to augment bone repair (osteogenic stimulation) can be performed either invasively or non-invasively.

10-005.13A Invasive Osteogenic Stimulation: Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. For percutaneously-placed cathodes, the power supply is externally placed and the leads connected to the inserted cathodes. For the implanted cathode, the power pack is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. NMAP covers use of the invasive device only for non-union of long bone fractures. NMAP considers non-union to exist only after six months or more have elapsed without the fracture healing.

10-005.13B Non-Invasive Osteogenic Stimulation: For the non-invasive device, opposing pads wired to an external power supply are placed over the cast. An electromagnetic field is created between the pads at the fracture site. NMAP covers use of the non-invasive device only for -

1. Non-union of long bone fractures;
2. Failed fusion; and
3. Congenital pseudoarthroses.

10-005.14 Biofeedback Therapy: Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Biofeedback therapy differs from electromyography, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. However, an electromyography device may be used to provide feedback with certain types of biofeedback.
Biofeedback therapy is covered under NMAP only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states, for psychosomatic conditions, or for psychiatric conditions.

10-005.15 Sleep Disorder Clinics: Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. NMAP covers diagnostic and therapeutic services of a sleep disorder clinic under the following conditions.

10-005.15A Diagnostic Services: All reasonable and necessary diagnostic tests given for the medical conditions listed in 471 NAC 10-005.15B are covered when the following criteria are met:

1. The clinic must be affiliated with a hospital;
2. Patients must be referred to the sleep disorder clinic by a physician. The clinic shall maintain a record of the attending physician’s orders; and
3. The need for diagnostic testing must be confirmed by medical evidence, e.g., physician examinations and laboratory tests.

Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered.

10-005.15B Medical Conditions for Which Diagnostic Testing is Covered: Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the following conditions. Most patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over. The overnight stay is considered an integral part of these tests.

1. Narcolepsy: This term refers to a syndrome that is characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep. Related diagnostic testing is covered if the patient has inappropriate sleep episodes or attacks (e.g., while driving, in the middle of a meal, in the middle of a conversation), amnesiac episodes, or continuous disability drowsiness. The sleep disorder clinic shall submit documentation that this condition is severe enough to interfere with the patient's well-being and health before Medicaid benefits may be provided for diagnostic testing. A maximum of three "sleep naps" to confirm a diagnosis of narcolepsy may be covered.
2. Sleep Apnea: This is a potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described - central, obstructive, and mixed. The nature of the apnea episodes can be documented by appropriate diagnostic testing. A maximum of one night stay per patient is covered by NMAP.

10-005.15C Therapeutic Services: Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Although only the diagnostic services indicated above are covered under Medicaid, therapeutic services may be covered provided they are standard and accepted services and are reasonable and medically necessary for the patient. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services may be provided for -

1. Insomnia;
2. Nocturnal myoclonus (muscle jerks);
3. Sleep apnea (typically central type);
4. Drug dependency;
5. Shift work and schedule disturbances;
6. Restless leg syndrome;
7. Hypersomnia (excessive daytime sleepiness);
8. Somnambulism;
9. Night terrors or dream anxiety attacks;
10. Enuresis; and

10-005.16 Portable X-Ray Services: NMAP covers diagnostic x-ray services provided by a certified portable x-ray provider when provided in a place of residence used as the patient's home and in nonparticipating institutions. These services must be performed under the general supervision of a physician and certain conditions relating to health and safety (see 471 NAC 10-005.16B) must be met.

NMAP also covers diagnostic portable x-ray services when provided in participating SNF's, under circumstances in which they cannot be covered as SNF services, i.e., the services are not provided by the participating institution either directly or under arrangements that allow the institution to bill for the services.

If portable x-ray services are provided in a participating hospital under arrangement, the hospital shall bill the Department for the service.
10-005.16A Certified Providers: To be approved as a provider under NMAP, providers of portable x-ray services must be certified by the CMS Regional Office.

For a Nebraska portable x-ray provider, the Division of Medicaid and Long-Term, Care staff must receive a copy of Form CMS-1539, "Medicare/Medicaid Certification and Transmittal" (see 471-000-66).

For an out-of-state portable x-ray provider, the Division of Medicaid and Long-Term Care shall request verification of certification from the CMS Regional Office. The Department approves or denies enrollment based on the certification information received from the CMS Regional Office.

The CMS Regional Office updates certification information and sends the information to the Department according to the federal time frame which is currently in effect for portable x-ray providers.

10-005.16B Applicability of Health and Safety Standards: The health and safety standards apply to all providers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services. Payment is made only for services of approved providers who have been found to meet the standards.

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

10-005.16C Covered Portable X-Ray Services: NMAP covers the following portable x-ray services:

1. Skeletal films involving arms and legs, pelvis, vertebral column, and skull;
2. Chest films which do not involve the use of contrast media (except, of course, routine screening procedures and tests in connection with routine physical examinations); and
3. Abdominal films which do not involve the use of contrast media.
10-005.16D Non-Covered Portable X-Ray Services: NMAP does not cover the following portable x-ray services:

1. Procedures involving fluoroscopy;
2. Procedures involving the use of contrast media;
3. Procedures requiring the administration of a substance to the patient or injection of a substance into the patient and/or special manipulation of the patient;
4. Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
5. Procedures requiring special technical competency and/or special equipment or materials;
6. Routine screening procedures; and
7. Procedures which are not of a diagnostic nature.

10-005.16E Billing Requirements: Claims for portable x-ray services must contain -

1. The name of the physician who ordered the service; and
2. The reason an x-ray test was required.

10-005.16F Electrocardiograms: The taking of an electrocardiogram tracing by an approved supplier of portable x-ray services may be covered as an "other diagnostic test." The health and safety standards in 471 NAC 10-005.16B must be met.

10-005.17 Durable Medical Equipment and Medical Supplies: NMAP does not generally approve hospitals as providers of durable medical equipment and medical supplies. Exception: Apnea monitors (see 471 NAC 10-005.22 ff.).

10-005.18 Hospital Dental Services: When dental treatment is necessary as a hospital inpatient or outpatient service, see 471 NAC 6-000.
10-005.19 Cardiac Stress Testing and Hospital Outpatient Cardiac Rehabilitation Programs:
Stress testing is a covered diagnostic procedure for evaluating chest pain and as a component in the development of rehabilitation exercise prescriptions for the treatment of patients with known cardiac disease provided that during the testing -

1. A physician is present;
2. Emergency equipment is available; and
3. A standard emergency procedure plan is in effect.

When the testing is done in the hospital inpatient or outpatient setting, these conditions are presumed to exist absent evidence to the contrary. However, the use of stress testing in the absence of any specific diagnostic or therapeutic purpose, e.g., for purposes such as work evaluation or coronary risk factor profile evaluation, are not covered as reasonable and necessary to the treatment of the patient's condition.

Outpatient cardiac rehabilitation programs consisting of individually-prescribed physical exercise or conditioning and concurrent telemetric monitoring are considered a valuable therapeutic modality for increasing the functional capacity of the cardiorespiratory reserve in certain stabilized cardiac patients, e.g., patients who have had a myocardial infarction and have reached the point where they are considered ready to commence physical activity consistent with their particular condition. When a program is provided by a hospital to its outpatients, the service is covered as an outpatient service.

Hospital outpatient services in connection with a cardiac rehabilitation exercise program are considered reasonable and necessary only during that period of time when the patient's condition is such that the exercises can only be carried out safely under the direct, continuing supervision of a physician and in a hospital environment. No more than 12 weeks (or 36 sessions) of a monitored exercise program is generally necessary for most patients to reach an acceptable level of individual exercise tolerance consistent with the particular stage of their disease. By this time the patient in most cases is physically and psychologically prepared to continue his/her exercise program at home on his/her own. Claims for services beyond a maximum duration of 12 weeks (or 36 sessions) must be accompanied by documentation supporting the patient's need for additional services.

Documentation must include -

1. Progress report and exercise sessions;
2. Diagnosis;
3. Cardiac history;
4. Risk factors;
5. Other medical problems;
6. Medications;
7. Allergies;
8. Personal habits;
9. Sources of stress, and support system; and
10. Treatment plan.
The monitoring required in these programs must be carried out by a hospital-employed nurse trained in cardiac rehabilitation, with a physician overseeing the monitoring. Although on occasion physical therapists and/or occupational therapists are involved in these programs, they generally act only as exercise leaders. These services do not constitute covered physical therapy or occupational therapy.

Since the type of cardiac rehabilitation exercise program which can be covered requires a hospital setting, this program is not covered in a skilled nursing facility.

10-005.20 Medical Transplants: NMAP covers transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the Medical Director of the Medicaid Division shall determine whether the transplant is medically necessary or non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance program covers liver or heart transplantation when the written opinions of two physicians specializing in transplantation state that a transplant is medically necessary as the only clinical practical, and viable alternative to prolong the patient's life in a meaningful, qualitative way and at a reasonable level of functioning.

NMAP is the payor of last resort.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 10-005.20D). An exception may be made for emergency situations, in which case verbal approval is obtained and the notification of authorization is sent later.

10-005.20A Services for an NMAP-Eligible Donor: NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 10-005.20D).

10-005.20B Services for an NMAP-Ineligible Donor: NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment for complications related to the donor is limited to those that are reasonably medically foreseeable.
NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are not directly related to the transplant.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 10-005.20D).

10-005.20C Billing for Services Provided to an NMAP-Ineligible Donor: Claims for services provided to an NMAP-ineligible donor must be submitted under the NMAP-eligible client's case number. There must be a notation on or in the claim that these services were provided to the NMAP-ineligible donor on the client's behalf.

10-005.20D Prior Authorization: Physicians shall request prior authorization before performing any transplant service or related donor service. This request for authorization must be submitted in writing or using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50) by the physician to:

The Medical Director
Medicaid Division
Nebraska Department of Health and Human Services Finance and Support
301 Centennial Mall South
P. O. Box 95026
Lincoln, Nebraska 68509

The request must include at a minimum:

1. The patient's name, age, diagnosis, pertinent past medical history and treatment to this point, prognosis with and without the transplant, and the procedure(s) for which the authorization is requested;
2. The patient's Nebraska Medicaid number;
3. Name of hospital, city, and state where the service(s) will be performed. The Department's policy regarding out-of-state services remains in effect. See 471 NAC 1-002.01F;
4. Name of physician(s) who will perform the surgery if other than physician requesting authorization; and
5. If authorization is requested for a liver or heart transplant, in addition to the above information, two physicians shall also supply the following:
   a. The screening criteria used in determining that a patient is an appropriate candidate for a liver or heart transplant;
   b. The results of that screening for this patient (i.e., the patient is eligible to be placed on "waiting list" in which the only remaining criteria is organ availability); and
c. A statement by each physician -
   (1) Recommending the transplant; and
   (2) Certifying and explaining why a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the client's life in a meaningful, qualitative way and at a reasonable level of functioning.

The Nebraska Department of Health and Human Services Finance and Support, Medical Director, shall send a response to the provider(s) advising them of the approval or denial of Medicaid payment of the requested transplant.

10-005.20E Payment for Liver or Heart Transplant Services: Only those services which are determined by the NMAP to be medically necessary and appropriate will be considered for Medicaid payment. The Department reserves the right to request any medical documentation from the patient's record to support and substantiate claims submitted to the Department for payment. These records may include but are not limited to office records, hospital progress notes, doctor's orders, nurses notes, consultative reports, hospital admission history and physical, and discharge summary.

10-005.20E1 Hospital Inpatient Services: Payment for hospital inpatient services is established under 471 NAC 10-010.03.

Procurement costs include removal of organ, transportation, and associated costs. These costs must be billed by the transplanting hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) and separately identified on the Medicare cost report. The hospital shall submit copies of the actual invoices for procurement costs, including transportation costs, on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

Payment of the technical component of inpatient laboratory and diagnostic and therapeutic radiology services is included in the hospital's payment for inpatient services.

10-005.20E2 Ambulatory Room and Board: The Department may cover ambulatory room and board services for liver or heart transplant patients (for the client and an attendant if necessary). All hospital outpatient charges associated with ambulatory stays are paid in accordance with 471 NAC 10-010.06 ff. Ambulatory room and board fees are paid using the appropriate HCPCS procedure codes. Also see 471 NAC 10-005.24 ff.

10-005.20E3 Hospital Outpatient Services: All services not provided on an inpatient basis will be paid at the rates established under NMAP. For laboratory and radiology services, see the elimination of combined billing regulations at 471 NAC 10-003.05C ff. Outpatient clinical laboratory services must be itemized using the appropriate HCPCS procedure code (see 471 NAC 10-010.06 ff.).
10-005.20E4 Physician Services: Surgeon(s) services will be paid according to the Nebraska Medicaid Practitioner Fee Schedule. This fee will include two weeks' routine post-operative care by the designated primary surgeon. Payment for routine post-operative care will not be made to other members of the surgical team.

Physician services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-005.21 Itinerant Physician Visits: NMAP covers non-emergency physician visits provided in a hospital outpatient setting if the services are -

1. Provided by an out-of-town specialist who has a contractual agreement with the hospital. NMAP does not consider general practitioners or family practitioners to be specialists; and
2. Determined to have been provided in the most appropriate place of service (see 471 NAC 10-010.09A).

The hospital room charge is considered the technical component of the visit and must be billed on Form CMS-1450 (UB-92) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The physician's service must be coded as an office visit and billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The physician will be paid at the rate for the appropriate level of office visit.

10-005.22 Infant Apnea Monitors: NMAP covers rental of home infant apnea monitors for infants with medical conditions that require monitoring due to a specific medical diagnosis only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent/caregiver training must occur before placement of infant apnea monitor. Parent/caregiver training is not reimbursed as a service separate from infant apnea monitor rental.

10-005.22A Medical Guidelines for the Placement of Home Infant Apnea Monitors: NMAP covers home infant apnea monitoring services for infants who meet one of the following criteria. NMAP defines infancy as birth through completion of one year of age.

1. Infants with one or more apparent life-threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking, or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hypoventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants of substance-abusing mothers, or infants with less severe ALTE's.
10-005.22A1 Removing the Infant from the Monitor: Criteria for removing infants from home infant apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when ALTE infants have had two-three months free of significant alarms or apnea where vigorous stimulation or resuscitation was not needed. Evaluating the infant's ability to tolerate stress (e.g., immunizations, illness) during this time is advisable.

The provider shall state the date of removal of the infant monitor on or in the final claim.

10-005.22B Approval of Home Infant Apnea Monitor Service Providers: NMAP covers rental of home infant apnea monitors and related supplies provided only by approved providers.

To ensure all home apnea monitoring needs of infants are met, the Department requires the development of a home infant apnea monitor "Coordination Plan." The "Coordination Plan" is not an individual patient plan; it is an overall program outline for the delivery of home apnea monitoring services. See 471 NAC 10-005.24, Coordination Plan Requirement for Certain Services.

10-005.22C Documentation Required After Initial Rental Period: Monitor rental exceeding the original two-month prescription period requires that an updated physician's narrative report of patient progress and a statement of continued need accompany the claim. A new progress report is required every two months. The report must include:

1. The number of apnea episodes during the previous prescription period;
2. The results of any tests performed during the previous prescription period;
3. Additional length of time needed; and
4. Any additional information the physician may wish to provide.

10-005.22D Limitations on Coverage of Apnea Monitor Equipment and Supplies: NMAP does not cover monitors that do not use rechargeable batteries.

NMAP does not make separate payment for remote alarms. If provided, payment for a remote alarm is included in the monitor rental.

Apnea monitor belts, lead wires, and reusable electrodes are covered for rented apnea monitors.

The following conditions must be met prior to initiation of home apnea monitoring:

1. History and physical assessment by the infant's attending physician; and
2. Parent/caregiver have successfully completed training on use of the equipment and any other physician recommended training (e.g., infant resuscitation and stimulation).
10-005.22D1 Pneumocardiograms: Pneumocardiograms are covered for diagnostic/evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation. This service must be billed by the physician performing the service.

10-005.22E Appropriate Hospital Services: Appropriate home infant apnea monitor services provided by a hospital with an approved infant apnea monitor "Coordination Plan" include rental of the apnea monitor, trend event recorder, and ECG/respirator recorder; purchase of related supplies; conversion of cassette recording to tape for interpretation; and CO₂/hypoxia studies. Payment for hospital apnea monitoring services provided to an inpatient is included in the hospital payment for inpatient services. Outpatient services and supplies provided by the hospital must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as hospital outpatient services.

10-005.22F Billing: The hospital shall bill for the technical component of infant apnea monitor services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). See 471 NAC 10-010.06 ff. The provider of the apnea monitor shall state the date of removal of the infant monitor on the claim.

Physicians' services must be billed as professional services on a CMS-1500 Form or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-005.23 Home Phototherapy: NMAP covers rental of home phototherapy (bilirubin) equipment for infants that require phototherapy when neonatal hyperbilirubinemia is the infant's sole clinical problem when prescribed by and used under the supervision of a physician.

10-005.23A Medical Guidelines for the Placement of Home Phototherapy Equipment: NMAP recognizes the Nebraska Chapter of the American Academy of Pediatric's Standard of Care for home phototherapy. Home phototherapy services will be covered when the following conditions are met:

1. Neonatal hyperbilirubinemia is the infant's sole clinical problem;
2. The infant is greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gm (5 lbs);
3. The infant is greater than 48 hours of age;
4. Bilirubin level at initiation of phototherapy (greater than 48 hours of age) is 14-18 mgs per deciliter; and
5. Direct bilirubin level is less than 2 mgs per deciliter.

Home phototherapy is not covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.
The following conditions must be met prior to initiation of home phototherapy:

1. History and physical assessment by the infant's attending physician has occurred. If home phototherapy begins immediately upon discharge from the hospital, the newborn discharge exam will suffice;

2. Required laboratory studies have been performed, including, CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin;

3. The physician certifies that the parent/caregiver is capable of administering home phototherapy;

4. Parent/caregiver have successfully completed training on use of the equipment; and

5. Equipment must be delivered and set up within 4 hours of discharge from the hospital or notification of provider, whichever is more appropriate. There must be a 24-hour per day repair and/or replacement service available.

At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

10-005.23B Discontinuing Home Phototherapy: Home phototherapy services will not be covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.

10-005.23C Approval of Home Phototherapy Providers: NMAP covers rental of home phototherapy equipment provided by approved providers. Physicians will not be approved as home phototherapy providers.

To ensure that home phototherapy needs of infants are met, the Department requires the development of a "Coordination Plan". The "Coordination Plan" is not an individual patient plan; it is an overall program outline for the delivery of home phototherapy services. See 471 NAC 10-005.24, Coordination Plan Requirement for Certain Services.

10-005.23D Documentation Required after Initial Rental Period: Home phototherapy services exceeding a three-day period require a physician's narrative report of patient progress and statement of continued need submitted with the claim.
10-005.23E Limitations on Coverage of Home Phototherapy Services: Services will be reimbursed on a daily basis. NMAP’s daily allowable fee includes:

1. Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
2. A minimum of one daily visit to the home by a licensed and/or certified "health care professional" as identified by the supplier in the "Coordination Plan" (see 471 NAC 7-006). The daily visits must include:
   a. A brief home assessment; and
   b. Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available. An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill NMAP directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home.
3. Complete caregiver training on use of equipment and completion of necessary records.

Payment for home phototherapy services does not include physician's professional services or laboratory and radiology services related to home phototherapy. These services must be billed by the physician or laboratory performing the service.

10-005.23F Billing for Home Phototherapy Services: Hospitals shall bill home phototherapy services in a summary bill format on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as outpatient services.

10-005.24 "Coordination Plan" Requirement for Certain Services: A "Coordination Plan" is an overall program outline for the delivery of a specific service; it is not an individual patient care plan. The following services will be reimbursed only to hospital providers with HHS F&S approved "Coordination Plans":

1. Apnea monitoring services; and
2. Phototherapy services.

A separate "Coordination Plan" is required for each type of service provided. The "Coordination Plan" must be submitted to and approved by the Medicaid Division prior to providing the service and must include:

1. A request for review of the "Coordination Plan" which includes the provider's name, address, phone number, contact person, and Medicaid provider number;
2. An overview of the services provided, including the provider's charge for the services;
3. Descriptions and literature on the equipment and all supplies and accessories provided;
4. Copies of all forms instructions, and record sheets for client use;
5. An outline of the training format used to train client on use of equipment and other training requirements (e.g., infant stimulation/resuscitation for apnea monitoring services);
6. The type and frequency of client contact (home visits, assessments, consultations, telephone follow-up, etc.) and identification and qualifications of personnel conducting client contacts; and
7. A statement of the provider's policy on equipment set-up, servicing, and availability for consultation on equipment problems.

After review of the "Coordination Plan, Medicaid Division staff shall notify the provider in writing of the "Coordination Plan" approval or disapproval.

The provider must notify the Medicaid Division of any changes in the "Coordination Plan".

10-005.25 Ambulatory Room and Board (Meals and Lodging): NMAP covers ambulatory room and board as a related transportation expense. NMAP covers ambulatory room and board only when the client is receiving NMAP coverable services and the following guidelines are met.

10-005.25A Definitions: The following definitions apply to ambulatory room and board services:

Ambulatory Room and Board Services: Meals and/or lodging determined to be necessary to secure NMAP coverable services, including medical examinations and treatment, for a client.

Attendant: A person who accompanies the client when the client is physically or mentally unable to travel or wait alone, including a child's parent or guardian.

10-005.25B Approval as an Ambulatory Room and Board Provider: NMAP approves only hospitals as ambulatory room and board providers. To receive NMAP payment, each hospital providing ambulatory room and board services must be enrolled with NMAP as a provider for hospital services and must submit Form MS-6, "Ambulatory Room and Board Agreement," (see 471-000-73) to:

Nebraska Department of Health and Human Services Finance and Support Medicaid Division P. O. Box 95026 Lincoln, NE 68509-5026

The Department may request additional information from the hospital to approve ambulatory room and board services. After review, Medicaid staff shall notify each hospital of the decision regarding provider approval for ambulatory room and board services.
10-005.25C Provider Re-Approval: Each hospital approved by the Department to provide ambulatory room and board services shall seek re-approval of its ambulatory room and board services from the Department when any of the following occur:

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

10-005.25D Guidelines: NMAP covers ambulatory room and board services as follows:

1. Ambulatory room and board services must be necessary to secure NMAP coverable services, including medical examinations and/or treatment.
2. NMAP covers meals when receipt of NMAP coverable services requires the client to be away from his/her home for 12 hours or longer;
3. NMAP covers lodging when an out-of-town overnight stay is necessary while receiving NMAP coverable services or if coverage of ambulatory room and board services will prevent a hospital inpatient stay; and
4. NMAP covers meals and lodging for up to one day before or after receiving services if extensive travel is necessary.

Payment for ambulatory room and board services outside these guidelines must be approved by the Medicaid staff.

10-005.25E Billing and Payment: The hospital shall bill for ambulatory room and board services provided by a Department-enrolled hospital as an outpatient service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using revenue code "995" and the appropriate HCPCS procedure codes.

Payment will be made using a hospital-specific rate. Payment to the hospital must not exceed its charge for services provided to the general public.
10-005.25F Documentation: The hospital must include a statement that documents the necessity for ambulatory room and board services for a client or for a client and an attendant on the hospital claim (see Claim Submission Table at 471-000-49.)

10-005.26 (Reserved)

10-005.27 Covered Services – Physical Therapy, Occupational Therapy, and Speech Pathology Services: Medicaid covers physical therapy, occupational therapy, and speech pathology services when the following criteria are met:

1. The services were ordered by a licensed physician;
2. The services are medically necessary;
3. The services are such a level of complexity and sophistication or the condition of the patient is such that only a qualified therapist can safely and effectively provide the service; and
4. The therapy service meets at least one of the conditions listed in 471 NAC 10-005.27A or 10-005.27B.

10-005.27A Services for Individuals Age 21 and Older: Medicaid covers a combined maximum total of 60 sessions per fiscal year (physical therapy, occupational therapy, and speech pathology services) for individual age 21 and older. The therapy services must be:

1. An evaluation; or
2. Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time; or
3. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.
10-005.27B  Services for Individuals Age 20 and Younger:  NMAP covers physical therapy, occupational therapy, and speech pathology services for individuals birth to age 20. The service must be:

1. An evaluation; or
2. Reasonable and medically necessary for the treatment of the client’s illness or injury; or
3. Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time; or
4. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver programs:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

10-005.27C  Non-Covered Physical Therapy, Occupational Therapy, and Speech Pathology Services:  NMAP does not cover therapy services in the following situations:

1. Clients Age 21 and Older – therapy sessions in excess of 60 sessions per fiscal year for any combination of physical therapy, occupational therapy, and speech therapy;
2. Therapy for vocational and prevocational assessment and training;
3. Therapy for functional capacity evaluations, educational testing, drivers training, or training in non-essential self-help or recreational activities (e.g. homemaking, cooking, finance), therapy related visual perception training, or for treatment of psychological conditions;
4. Therapy for dysfunctions that are self-correcting, such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting;
5. Therapy for delays in speech development that are not due to a specific disease or brain injury; or
6. Therapy for the following condition or diagnosis categories:
   a. Psychosocial speech delay;
   b. Behavior problems;
   c. Attention disorders;
   d. Conceptual handicap; or
   e. Learning disability.

10-006 through 10-009  (Reserved)
10-010 Payment for Hospital Services

10-010.01 (Reserved)

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for the Nebraska Medical Assistance Program excluding Nebraska Medicaid Managed Care Program’s capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. Specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. Provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. Takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective using methods established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

Each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio.

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

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

APR-DRG: The All-Patient Refined Diagnosis-Related Group software application that assigns patients into categories based on severity of illness and risk of mortality.

Base Year: The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.
Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in 471 NAC 10-010.03B5 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital licensed as a Critical Access Hospital by the Department of Health and Human Services under 175 NAC 9 and certified for participation by Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, birth weight, procedure coding, comorbidity, and complications.

Direct Medical Education Cost Payment: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.

Disproportionate Share Hospital (DSH): A hospital located in Nebraska is deemed to be a disproportionate share hospital by having -

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

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

DRG Weight: A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each DRG and Severity of Illness (SOI).

Health Care-Acquired Conditions: A health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Hospital-Acquired Condition: A condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission.
Hospital Mergers: Hospitals that have combined into a single corporate entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

Hospital-Specific Base Year Operating Cost: Hospital-specific operating allowable cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Hospital-Specific Cost-to-Charge Ratio: Hospital-Specific Cost-to-Charge Ratio is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-Specific Cost-to-Charge Ratios used for outlier cost payments and Transplant DRG CCR payments are derived from the outlier CCRs in the Medicare inpatient prospective payment system.

Indirect Medical Education Cost Payment: Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education payments.

Low-Income Utilization Rate: For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum (expressed as a percentage) of the fractions, calculated from acceptable data submitted by the hospital as follows:

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

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

Medicaid Allowable Inpatient Charges: Total claim submitted charges less claim non-allowable amount.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.
Medicaid Inpatient Utilization Rate: The ratio of (1) allowable Medicaid inpatient days, as determined by NMAP, to (2) total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out-of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

Medicaid Rate Period: The period of July 1 through the following June 30.

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

Medicare Cost Report: The report filed by each facility with its Medicare intermediary.

The Medicare cost report is available through the National Technical Information Service at the following address:

U.S. Department of Commerce
Technology Administration
National Technical Information Service
Springfield, VA 22161

A hospital that does not participate in the Medicare program shall complete the Medicare Cost Report in compliance with Medicare principles and supporting rules, regulations, and statutes (i.e., the provider shall complete the Medicare cost report as though it was participating in Medicare).

The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees (see 471 NAC 10-010.03S). Note: If a nursing facility (NF) is affiliated with the hospital, the NF cost report must be filed according to 471 NAC 12-011 ff. Note specifically that time guidelines for filing NF cost reports differ from those for hospitals.

New Operational Facility: A facility providing inpatient hospital care which meets one of the following criteria:

1. A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;
2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.

**Note:** A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

**Operating Cost Payment Amount:** The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

**Other Provider-Preventable Conditions (OPPC):** A wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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

1. **Metro Acute Care Hospitals:** Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. **Other Urban Acute Care Hospitals:** Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. **Rural Acute Care Hospitals:** All other acute care hospitals;
4. **Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals:** Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. **Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals:** Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. **Critical Access Hospital:** Hospitals that are certified as critical access hospitals by Medicare.

**Peer Group Base Payment Amount:** A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group except Peer Group 5 and Peer Group 6.

**Present on Admission (POA) Indicator:** A status code the hospital uses on an inpatient claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs.

**Provider-Preventable Conditions (PPC):** An umbrella term which is defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).
Reporting Period: Same reporting period as that used for its Medicare cost report.

Resource Intensity: The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

Risk of Mortality (ROM): The likelihood of dying.

Severity of Illness Level (SOI): The extent of physiologic decompensation or organ system loss of function.

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

Uncompensated Care: Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

10-010.03B Payment for Peer Groups 1, 2, and 3 (Metro Acute, Other Urban Acute, and Rural Acute): Payments for acute care services are made on a prospective per discharge basis, except hospitals certified as a Critical Access Hospital.

For inpatient services, the total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
   a. Direct Medical Education Cost Payment;
   b. Indirect Medical Education Cost Payment; and
   c. A Cost Outlier Payment.

For inpatient services that are classified into a transplant DRG, the total per discharge payment is the sum of -

1. The Cost-to-Charge Ratio (CCR) Payment amount; and
2. When applicable - Direct Medical Education Cost Payment.

10-010.03B1 Determination of Operating Cost Payment Amount: The hospital DRG operating cost payment amount for discharges that are classified into a DRG is calculated by multiplying the peer group base payment amount by the applicable national relative weight.
10-010.03B1a Calculation of the APR-DRG Weights: For dates of service on and after July 1, 2014, the Department will use the All-Patient Refined Diagnosis Related Groups (APR-DRG) national relative weights to determine DRG classifications. The national weights are based on 3M’s APR-DRG standard national weights. The Department will annually update the APR-DRG grouper and national relative weights with the most currently available version.

10-010.03B1b Calculation of the Starting Point for the Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges for non-transplant DRG. For purpose of rate setting, the starting point shall be the Medicaid Peer Group Base Payment Amount effective on July 1 of state fiscal year (SFY) 2011.

SFY 2010 Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B1b in effect July 1, 2010. For the purpose of maintaining budget neutrality with the APR-DRG grouper system, the state fiscal year (SFY) 2011 Peer Group Base Rates will be increased by 61.05 percent.

10-010.03B1b(1) Adjustment Based on Legislative Appropriations: The starting point for the peer group base payment amounts, as determined in section 10-010.03B1b, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The Peer Group Base Payment Amounts are adjusted annually and shall be effective each July 1.

10-010.03B2 Calculation of DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a DRG meeting or exceeding Medicaid criteria for cost outliers for each DRG classification. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $30,000 for all neonate and nervous system APR-DRGs at severity level 3 and severity level 4.
For all other APR-DRGs, the outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $51,800. Cost of the discharge is calculated by multiplying the Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is 80 percent of the difference between the hospital’s cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85 percent of the difference between the hospital’s cost for the discharge and the outlier threshold.

10-010.03B2a Hospital Specific Medicare Outlier CCRs: The Department will extract from the CMS PPS Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier CCRs effective October 1 of the year preceding the start of the Nebraska rate year.

10-010.03B2b Outlier CCRs Updates: On July 1 of each year, the Department will update the outlier CCRs based on the Medicare outlier CCRs effective October 1 of the previous year.

10-010.03B3 Calculation of Medical Education Costs:
10-010.03B3a Calculation of Direct Medical Education Cost Payments:

Direct Medical Education (DME) payments are based on Nebraska hospital-specific DME payment rates effective during SFY 2010.

SFY 2010 Nebraska hospital-specific DME payment rates are described in 471 NAC 10-010.03B in effect July 1, 2010. Each SFY Nebraska hospital-specific DME payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The DME payment rates are adjusted annually and shall be effective each July 1.

On July 1st of each year, the Department will update DME payment rates by replacing each hospital's intern and resident FTEs with each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1 of the previous year.

10-010.03B3b Calculation of Indirect Medical Education (IME) Cost Payments:

Hospitals qualify for IME payments when they receive a direct medical education payment from the Department, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the operating cost payment amount.

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program using the following formula:

\[ \left[1 + \frac{\text{Number of Interns and Residents/Available Beds}}{0.405} \right] \times 1.35 \]

On July 1 of each year, the Department will adopt the Medicare inpatient prospective payment system operating IME factor formulas and rate components in effect on October 1 of the previous year.
10-010.03B3c Calculation of Managed Care Organization (MCO) Medical Education Payments: The Department will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by capitated plans from discharge data provided by the plans.

1. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the fee-for-service direct medical education payment per discharge.

2. MCO Indirect Medical Education payments will be equal to the fee-for-service IME operating factor multiplied by the MCO operating payments.
10-010.03B4 Calculation of Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of stay for the DRG. Capital-related payment per diem amounts are calculated for Peer Group 1, 2, and 3 hospitals based on the Capital-related payment per diem amounts effective during SFY 2010.

The Base Capital-Related Cost Payments per diem amounts are described in 10-010.03B4 in effect on July 1, 2010. Each SFY the peer group specific capital-related payment per diem amounts shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The capital-related payment rates are adjusted annually and shall be effective each July 1.

10-010.03B5 (Reserved)

10-010.03B6 Transplant DRG Payments: Transplant discharges, identified as discharges that are classified to a transplant DRG, are paid a Transplant DRG CCR payment and, if applicable, a DME payment. Transplant DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B6a Transplant DRG CCR Payments: are calculated by multiplying the hospital-specific Transplant DRG CCR by Medicaid allowed claim charges.

On July 1 of each year, the Department will update the Transplant DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years.

Each SFY Nebraska hospital-specific transplant DRG CCR payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

10-010.03B6b Transplant DRG DME Payments: Transplant DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation.

On July 1 of each year, the Department will update Transplant DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.
10-010.03B7 (Reserved)

10-010.03B8 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1, 2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services shall not exceed 110 percent of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B8a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility’s cost report. A final reconciliation will be made within 6 months following receipt by the Department of the facility’s settled cost report. Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110 percent of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B9 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.
For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100% of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

10-010.03B10 Inpatient Admission After Outpatient Services: Effective January 1, 2002 and after, a patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. Inpatient services, for billing and payment purposes, includes nonphysician outpatient services rendered on the day of admission or during the inpatient stay, diagnostic services rendered up to three days before the day of admission, and admission related nondiagnostic services rendered up to 3 days before the day of admission. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

10-010.03B11 Readmissions: NMAP adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All NMAP patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

10-010.03B12 Interim Payment for Long-Stay Patients: NMAP's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days.

To request an interim payment, the hospital shall send the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to the Department of Health and Human Services, Division of Medicaid and Long-Term Care.

The hospital will be notified in writing if the request for interim payment is denied.
10-010.03B12a Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement "from" and "to" dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

10-010.03B13 Payment for Non-physician Anesthetist (CRNA) Fees: Hospitals which meet the Medicare exception for payment of CRNA fees as a pass-through by Medicare will be paid for CRNA fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for CRNA services. Costs will be calculated using the hospital's specific anesthesia cost to charge ratio. CRNA fees must be billed using revenue code 964 - Professional Fees Anesthetist (CRNA) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

10-010.03C Non-Payment for Hospital Acquired Conditions: NMAP will not make payment for those claims which are identified as non-payable by Medicare as a result of avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This provision applies only to those claims in which Medicaid is a secondary payor to Medicare.

10-010.03D Payments for Psychiatric Services: Payments for psychiatric discharges are made on a prospective per diem.

Tiered rates will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission, but not the day of discharge.

Mental health and substance abuse services provided to clients enrolled in the NMMCP for the mental health and substance abuse benefits package will be reimbursed by the plan.
10-010.03D1: For payment of inpatient hospital psychiatric services, for the purpose of rate setting, the starting point shall be the tiered per diem amount effective on July 1 of state fiscal year (SFY) 2010. The starting point shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The tiered per diem amounts are adjusted annually and shall be effective each July 1.

10-010.03D2 Payment for Hospital Sponsored Psychiatric Residential Treatment Facilities (PRTFs): Payments for hospital sponsored PRTFs are made on a prospective per diem basis. The starting point for the rate was developed using standardized expense reports. Medicaid will not pay more than the facility’s usual and customary daily charges billed for eligible clients. Pharmacy and physician services may be billed separately apart from the facility per diem. Public PRTFs will be cost-settled annually. Payment rates do not include costs of providing educational services. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The prospective payment amounts are adjusted annually and shall be effective each July 1.

10-010.03D3 Payment for Psychiatric Adult Inpatient Subacute Hospital Services: Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all inclusive per diem, with the exception of physician services. The starting point shall be the per diem amount effective on July 1 of state fiscal year (SFY) 2010. The starting point shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The per diem payment amounts are adjusted annually and shall be effective each July 1.
10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of –

1. The hospital-specific base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission but not for the day of discharge.

10-010.03E1 Calculation of Hospital-Specific Base Payment Amount: The hospital-specific base payment per diem is calculated as 100 percent of the median of the hospital-specific base year operating costs for the base year per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units.

10-010.03E2 Adjustment of Hospital-Specific Base Payment Amount: Each SFY, the hospital-specific base payment amount shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The hospital-specific base payment amounts are adjusted annually and shall be effective each July 1.
10-010.03E3 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem as described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

10-010.03F1 Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.03F, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

10-010.03G Rates for State-Operated IMD’s: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD’s will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for Medicaid. This requirement does not apply to a hospital:
   a. The inpatients of which are predominantly individuals under 18 years of age; or
   b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.
   c. For a hospital located in a rural area, the term "obstetrician” includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. Only Nebraska hospitals which have a current enrollment with Nebraska Medicaid will be considered for eligibility as a Disproportionate Share Hospital.
10-010.03H1 Disproportionate Share Eligibility Calculation: To calculate eligibility, proxy data will be used from each hospital’s fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a Disproportionate Share Hospital will be calculated using the following data:

1. To determine the Medicaid Inpatient Utilization Rate, the denominator will be the total days as reported on the Medicare Cost Report. The numerator will be the sum of each hospital’s Medicaid days, which includes the MMIS claims file data run 150 days after each hospital’s fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made. Only secondary payor days in the MMIS claims file data will be included.

2. To determine the Low-Income Utilization Rate, data from the Nebraska Accounting System will be used to calculate the Low-Income Utilization Rate for State-Owned Institutions for Mental Disease (IMDs). For all other hospitals, the hospital’s certified report of total revenue, Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

10-010.03H2 Disproportionate Share Hospital (DSH) Upper Payment Limit and Uncompensated Care Calculation: The Disproportionate Share Hospital upper payment limit and the uncompensated care calculation is the sum of the Medicaid shortfall plus the cost of uninsured care.

1. The Department will calculate the Medicaid shortfall as follows:
   a. The Department will determine the costs of Medicaid fee-for-service and managed care inpatient services by:
      (1) Calculating a hospital’s routine cost per day for each cost center (e.g., Adult, Pediatrics, etc.) from the CMS 2552 cost report by dividing the total costs by the total days; and
      (2) Multiplying the cost per day times the number of Medicaid allowable days provided during the same fiscal year as the filed cost report, and paid up to 150 days after the end of the fiscal year.
   b. The Department will determine costs of Medicaid fee-for-service and managed care outpatient services by:
      (1) Calculating a hospital’s ancillary cost to charge ratio from the CMS 2552 cost report; and
(2) Multiplying the total Medicaid allowable charges times the ancillary cost to charge ratio.

c. The total Medicaid cost is the sum of the inpatient and outpatient costs for each hospital.

d. The Medicaid shortfall is determined by subtracting the total allowable Medicaid payments from the total Medicaid cost.

2. The Department will calculate the cost of uninsured care by using each hospital’s charges for services provided to uninsured patients as filed and certified to the Department for the same fiscal year as the CMS cost report used in determining costs. The Department will convert each hospital’s charges to cost for uninsured patients by multiplying the charges by the overall cost-to-charge ratio determined using hospital’s CMS 2552 report for the same fiscal year used in determining cost.

3. The Medicaid upper payment limit and the uncompensated care amount is the sum of the Medicaid shortfall plus the cost of uninsured care.

10-010.03H3 Disproportionate Share Payments: Disproportionate share payments will be made annually for each federal fiscal year (FFY) following receipt of all required data by the Department. The total of all disproportionate share payments must not exceed the limits on disproportionate share hospital funding as established for this State by the Centers for Medicare and Medicaid Services (CMS) in accordance with the provisions of the Social Security Act, Title XIX, Section 1923. Payments determined for each federal fiscal year will be considered payment for that year, and not for the year from which proxy data used in the calculation was taken. To calculate payment, proxy data will be used from each hospital’s fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination will be applied.

10-010.03H3a For FFY07 and succeeding years, the Department will make a disproportionate share hospital payment to hospitals that qualify for a payment under one of the following pool distribution methods.

10-010.03H3a(1) Basic Disproportionate Share Payment (Pool 1): Pool 1 consists of eligible hospitals in Peer Groups 2, 3, and 6 that are not eligible under Pool 6.

10-010.03H3a(1)(a) Total funding to Pool 1 will be $1,000,000. In FFY 2008 and following years, this amount will be increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment as follows:

1. First, each hospital’s Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital’s fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the
Medicaid inpatient days of all hospitals which qualify for a payment in Pool 1.

2. Second, the ratio resulting from the division will be multiplied by the total funding for Pool 1 to determine each hospital’s payment.

3. If payment to a hospital exceeds the disproportionate share hospital payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.

4. If payment is reduced to a hospital within Pool 1, the additional funds will be redistributed prorata to eligible hospitals within Pool 1.

10-010.03H3a(2) Basic Disproportionate Share Payment (Pool 2): Pool 2 consists of eligible hospitals in Peer Groups 1, 2, and 3 that are also eligible under Pool 6.

10-010.03H3a(2)(a) Total funding to the Pool 2 will be $3,154,000 for FFY 2007, and $2,654,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment for Pool 2 as follows:

1. First, each hospital’s Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital’s fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 2.

2. Second, the ratio resulting from the division will be multiplied by the total funding for Pool 2 to determine each hospital’s payment.

3. If payment to a hospital exceeds the disproportionate share hospital payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.

4. If payment is reduced to a hospital within Pool 2, the additional funds will be redistributed prorata to eligible hospitals within Pool 2.

10-010.03H3a(3) Disproportionate Share Payment for Hospitals that Primarily Serve Children (Pool 3): Pool 3 consists of the hospital that both primarily serves children age 20 and under and has the greatest number of Medicaid days.
Total funding for Pool 3 will be $3,138,000 for FFY 2007, and $3,638,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). A hospital eligible for payment under this pool will not be eligible for payment under any other pool. If payment to the hospital exceeds the disproportionate share hospital payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.


Total funding for Pool 4 will be $1,811,337 annually. The Department will calculate payments as follows:

1. Each eligible hospital must certify in writing to the Nebraska Medical Assistance Program its charges for uncompensated care for the hospital’s fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospital’s cost-to-charge ratio.
2. Payment to each hospital will be equal to the cost of its uncompensated care.
3. If the total of all disproportionate share payment amounts for Pool 4 exceeds the federally determined disproportionate share limit for Nebraska, the DSH payments will be reduced prorata.
4. A hospital eligible for payment under this pool will not be eligible for payment under any other pool.
10-010.03H3a(5) Non-Profit Acute Care Teaching Hospital Affiliated with a State-Owned University Medical College (Pool 5): Pool 5 consists of the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this pool may be eligible for payment under Pool 6.

10-010.03H3a(5)(a) Total funding to pool 5 will be $15,000,000. For FFY 08 and following years, the pool will be increased annually by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the DSH payment to Pool 5 as an amount equal to the cost of its uncompensated care. If the payment to the hospital exceeds the disproportionate share payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.

10-010.03H3a(6) Uncompensated Care Pool (Pool 6): Pool 6 consists of hospitals that provide services to low income persons covered by a county administered general assistance (GA) program; or hospitals that provide services to low-income persons covered by the state administered public behavioral health system.

10-010.03H3a(6)(a) Total funding to Pool 6 will be the remaining balance of the total (federal and state) DSH funding minus the funding for Pools 1, 2, 3, 4, and 5. The Department will calculate payments as follows:
1. DSH payments to a hospital under all other pools will be subtracted from the hospital's upper payment limit before allocating payments under Pool 6.

2. The costs for uncompensated care resulting from participation in the county administered general assistance (GA) program will be reported and funding transferred by the county; and costs for the state administered public behavioral health system will be reported by each hospital and funding transferred to the Medicaid agency. Reported costs will be subject to audit.

3. A ratio for each hospital will be determined based on the uncompensated cost amount transferred for each hospital to the total uncompensated cost transferred for all hospitals in Pool 6.

4. The ratio for each hospital will be multiplied by the available funding to the Pool.

5. The total computable payment will be commensurate with the transferred amount for uncompensated care resulting from participation in county administered general assistance (GA) program; or the state administered public behavioral health system as the state matching shares.

6. The annual payment amount will be dispersed in twelve monthly payments as transferred to the Medicaid agency.

7. If payment to the hospital exceeds the disproportionate share payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced to the payment limit.

8. If payments to hospitals under this pool exceed the total funding to the pool, the payments will be reduced prorata.

10-010.03H3b Limitations on Disproportionate Share Payments: The Department will apply the following limitations to disproportionate share payments:

1. No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923(g)(1)(A) of the Social Security Act.

2. Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923(f) of the Social Security Act.
10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services using the same methods described in this regulation for in-state hospitals, except that out-of-state hospitals do not receive direct medical education cost payments or indirect medical education cost payments. Payments for services are determined by assigning out-of-state hospitals to the appropriate peer group. The peer groups are:

1. **Metro Acute Care Hospitals:** Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare;
2. **Rural Acute Care Hospitals:** All other acute care hospitals;
3. **Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals:** Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.
4. **Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals:** Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.

For peer groups 1 and 3, operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the appropriate peer group capital per diem rate. The cost-to-charge ratios for out-of-state hospitals that meet the criteria for inclusion in the calculation of DRG at section 10-010.03B1a of this regulation are determined using the same method described for in-state hospitals in Section 10-010.03B of this regulation. The cost-to-charge ratios for all other out-of-state hospitals are the peer group average of in-state hospitals.

Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

Tiered rates as described in 471 NAC 10-010.03D1, will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payments for rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Payments for rehabilitation hospitals are based on average of the in-state hospital specific per diem rates for the appropriate type of service. Capital-related cost payments are made based on the in-state peer group capital per diem rate.
10-010.03J1 Exception: The Administrator of the Medicaid Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in 471 NAC 10-010.03J only when the Medical Director of the Department has determined that:

1. The client requires specialized services that are not available in Nebraska; and
2. No other source of the specialized services can be found to provide the services at the rate established in 471 NAC 10-010.03J.

10-010.03K Out-of-Plan Services: When enrollees in the Nebraska Health Connection are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are authorized, but are not required, to pay providers of hospital inpatient services who care for individuals enrolled in the Nebraska Health Connection at rates the Department would otherwise reimburse providers under 471 NAC 10-010.03ff.

10-010.03L Free-Standing Psychiatric Hospitals: When a free-standing psychiatric hospital (in Nebraska or out of state) does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service shall bill NMAP for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. The hospital's rate is calculated according to 471 NAC 10-010.03D, and/or 10-010.03J. This is an exception to regulations governing the elimination of combined billing in 471 NAC 10-003.05C through 10-003.05F6e.

10-010.03M Rate-Setting Following a Change in Ownership: The rate-setting process for facilities with a change in ownership will be the same as the rate-setting process used prior to the change in ownership as described in these regulations.

10-010.03N Rate-Setting Following a Hospital Merger: Hospitals that have combined into a single entity shall be assigned a single combined weighted average for each of the following: direct medical education amount, if applicable, indirect medical education amount, if applicable, cost-to-charge ratio, outpatient percentage, capital amount, and any other applicable rates or add-ons. The weights shall equal each hospital's base year Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the current fiscal year rates which were calculated for each hospital.
10-010.03O Rate-Setting for a New Operational Facility: The Department shall establish a prospective per discharge rate for a new operational facility for Peer Groups 1-5. The rate will be the average peer group rate for the respective peer group for the new facility. For critical access hospitals, the rate will be determined individually for each hospital based on reasonable cost. The peer groups are -

1. **Metro Acute Care Hospitals**: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. **Other Urban Acute Care Hospitals**: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as a Regional Rural Referral Center;
3. **Rural Acute Care Hospitals**: All other acute care hospitals with 30 or more base year Medicaid discharges;
4. **Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals**: Hospitals that are licensed as psychiatric hospitals by the Nebraska Department of Health and Human Services Regulation and Licensure and distinct parts as defined in these regulations;
5. **Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals**: Hospitals that are licensed as rehabilitation hospitals by the Nebraska Department of Health and Human Services Regulation and Licensure and distinct parts as defined in these regulations.
6. **Critical Access Hospital**: Hospitals that are certified as critical access hospitals by Medicare.

10-010.03P Depreciation: The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

10-010.03Q Recapture of Depreciation: A hospital which is sold for a profit and has received NMAP payments for depreciation shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department; or
2. The product of -
   a. The ratio of Medicaid allowed inpatient days to total inpatient days; and
   b. The amount of gain on the sale as determined by the Medicare intermediary.

\[
\text{# of Medicaid Inpatient Days} \times \frac{\text{Gain on Sale in $}}{\text{Total # of Inpatient Days}} = \text{Recapture Amount}
\]

The year(s) for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.
10-010.03R Adjustment to Rate: Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current and/or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital shall refund the overpayment amount as determined by the Department to the Department. If the rate adjustment results in increasing a hospital's rate, the Department shall reimburse the underpayment amount as determined by the Department to the hospital.

10-010.03S Lower Levels of Care: When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year.

When a Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process (PASP), the Department may pay for the PASP days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. The hospital shall request prior authorization from the Medicaid Division before the PASP days are provided. The Medicaid Division will send the authorization to the hospital. The hospital shall bill the appropriate bill type and revenue code and enter the prior authorization document number from Form MC-9 on Form CMS-1450 or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278). The claim for the PASP days must be separate from the claim for the inpatient days paid at the acute rate. The PASP days will be disallowed as acute care days and NMAP will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the PASP day. PASP days will not be considered in computing the hospital’s prospective rate.

10-010.03T Access to Records: Hospitals shall make all records relating to the care of Medicaid patients and any and all other cost information available to the Department, its designated representatives or agents, and/or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

Hospitals shall allow authorized representatives of the Department of Health and Human Services Finance and Support, the federal Department of Health and Human Services, and state and federal fraud and abuse units to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department. The hospital shall allow the authorized representatives access for the purpose of audit and review at any reasonable time during normal working hours upon written notice by the Department at least one working day before the review and audit.
10-010.03U Audits: The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

10-010.03V Provider Appeals: A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date according to the procedures in 471 NAC 2-003 ff. A hospital may also request an adjustment to its rate (see 471 NAC 10-010.03W).

10-010.03W Request for Rate Adjustments: Hospitals may submit a request to the Department for an adjustment to their rates for the following:

1. An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate if the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate.
2. Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate for extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. Extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. Extraordinary circumstances are limited to -
   a. Changes in routine and ancillary costs, which are limited to -
      (1) Intern and resident related medical education costs; and
      (2) Establishment of a subspecialty care unit;
   b. Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.
3. Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:
   a. One-time occurrence;
   b. Less than twelve-month duration;
   c. Could not have been reasonably predicted;
   d. Not of an insurable nature;
   e. Not covered by federal or state disaster relief;
   f. Not a result of malpractice or negligence.

In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital.

If an adjustment is granted, the peer group rates will not be changed.
In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following:

1. Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control.

2. Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.

3. The rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.

Requests for rate adjustments must be submitted in writing to the Administrator, Medicaid Division, Nebraska Department of Health and Human Services Finance and Support. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, the Department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Department's receipt of the request. Regardless of the Department's decision, the provider will be afforded the opportunity for a conference if requested for a full explanation of the factors involved and the Department's decision. Following review of the matter, the Administrator shall notify the facility of the action to be taken by the Department within 30 days of receipt of the request for review or the date of the conference, except in circumstances where additional information is requested or additional investigation or analysis is determined to be necessary by the Department.

If rate relief is granted as a result of a rate adjustment request, the relief applies only to the rate year for which the request is submitted (except for corrections of errors in rate determination). If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.

Under no circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology.

10-010.03X Administrative Finality: See 471 NAC 3-002.10.

10-010.04 (Reserved)

10-010.05 (Reserved)
10-010.06 Payment for Outpatient Hospital and Emergency Room Services: The starting point for the outpatient hospital and emergency services rate shall be a rate which is the product of:

1. Seventy-five (75) percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The effective date of the cost-to-charges ratio is the first day of the month following the Department's receipt of the cost report. Each state fiscal year, the outpatient hospital and emergency services rate shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. Outpatient hospital and emergency services rates shall be effective each July 1.

Providers shall bill outpatient hospital and emergency room services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services at the fee schedule determined by CMS. See 471-000-520 and 471 NAC 10-003.05F5b.

10-010.06A Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Payment for outpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. The Department will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made at the reasonable cost of providing these services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility’s provider number. To avoid any interruption of payment, the Department will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

10-003.06A1 Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.06A, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

10-010.06B Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to 471 NAC 26-005.
10-010.06C Payment for Outpatient Mental Health and Substance Abuse Services in a Hospital: Providers shall use HCPCS procedure codes when submitting claims to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

1. **Level 1**: The codes contained in the most recently published edition of the American Medical Association’s Current Procedural Terminology (CPT); and

2. **Level 2**: Federally defined alpha-numeric HCPCS codes.

The Nebraska Medical Assistance Program (Medicaid) pays for covered outpatient mental health services, except for laboratory services, at the lower of –

1. The provider’s submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as –
   a. The unit value multiplied by the conversion factor;
   b. The maximum allowable dollar amount; or
   c. The reasonable charge for the procedure as determined by Medicaid (indicated as “BR” – by report or “RNE” – rate not established in the fee schedule).

HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518 and 471-000-532).

10-010.06C1 Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to –

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally recognized systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when Medicaid determines that the current allowable amount is –
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

See 471 NAC 20-002.11 and 13 and 471 NAC 32-002.11 and 15.
**10-010.06D Approval of Payment for Emergency Room Services:** At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for an emergency medical condition, (see emergency medical condition in 471 NAC 10-001.02);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by his or her physician for treatment in an emergency room.

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency medical condition and bill accordingly.

When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of what would otherwise be allowed. All other Medicaid allowable charges incurred in this type of visit will be paid according to 471 NAC 10-010.06.

**10-010.06E Diagnostic and Therapeutic Services:** The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as state fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

**10-010.06F Payment to a New Hospital for Outpatient Services:** See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (a new operational facility) will be made at the statewide average ratio of cost to charges for Nebraska hospitals as determined by the Department according to 471 NAC 10-010.06. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department according to 471 NAC 10-010.06.

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 et seq.)

**10-010.06G Payment to An Out-of-State Hospital for Outpatient Services:** Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges for all Nebraska hospitals. See 471 NAC 10-010.06.
10-010.07 (Reserved)

10-010.08 Administrative Finality: See 471 NAC 3-002.10.

10-010.09 Limitations on Payment for Hospital Services

10-010.09A Place of Service: The Medical Services Division may review and reduce or deny payment for covered outpatient or emergency room drugs, supplies, or services which are readily obtainable from another provider (i.e., pharmacy, physician’s office) at the time provided to the amount payable at the least expensive appropriate place of service.

10-010.09B Items Not Utilized in the Facility: Drugs, medical supplies, and services not utilized in the hospital must be obtained from and billed by the appropriate provider. Exception: Take-home supplies.

Also see 471 NAC 10-003.02C regarding take-home drugs and 471 NAC 10-003.03C regarding take-home supplies.

NMAP does not cover drugs, supplies, and services not utilized in the hospital for nursing home residents when billed by the hospital because payment is included in the nursing home per diem.

10-010.09C Outpatient/Emergency Services on the Same Day as Inpatient Services: When a client receives outpatient/emergency room hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the outpatient/emergency room hospital services are treated as inpatient services for billing purposes.

10-010.09D Billed Charges: Inpatient hospital services are paid on a prospective rate basis, regardless of billed charges.

10-010.10 Medically Unnecessary Inpatient Hospitalization: See 471 NAC 3-001.10.

10-010.11 NMAP’s Surveillance and Utilization Review of Hospital Services: The Nebraska Department of Health and Human Services Finance and Support or its designee reviews hospital inpatient services for medical necessity, appropriateness of service, and level of care. The review may also include validation of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, continued hospitalization, discharge, and transfer; and appropriateness of prospective payment outlier cases.
10-010.11A Review Activities for Hospital Inpatient Services Reimbursed on a Prospective Per Discharge Basis: All hospital inpatient services reimbursed on a prospective per discharge basis (by DRG) are subject to random retrospective review by the Department or its designee. Admissions within three calendar days of a hospital outpatient service may be included in the sample. In addition to the random sample, focused reviews of inpatient stays for heart or liver transplant(s), NICU stays provided in a subspecialty care facility and/or cost outliers may be done by the Department or its designee.

Review for all selected cases will include: DRG validation, including validation of diagnostic and procedural information and ICD-10-CM coding; medical necessity for inpatient admission and procedure(s); stability at discharge; and quality of care. Payment for inpatient services can be denied if either admissions or discharges are performed without medical justification as determined by the Department or its designee. Payment can be reduced if coding inaccuracies are identified by the Department or its designee. Any cost outlier which is not determined to be medically necessary for hospital inpatient care by the Department or its designee may qualify for payment as a lower level of care payment.

10-010.11B Review Activities for Hospital Inpatient Services Reimbursed on a Prospective Per Diem Basis: Hospital inpatient care must be reasonable, medically necessary, and appropriate for the class of care being billed. All hospital inpatient admissions (see exceptions below) must be certified by the Department or its designee prior to payment. Review will include medical necessity, appropriateness of service, and level of care. Payment for services will be denied if the Department or its designee determines the service was not medically necessary. The Department or its designee will conduct these activities through pre-admission, concurrent, and retrospective reviews.

If the class of care is not appropriate, the claim may be reduced to the appropriate level of care according to 471 NAC 10-010.03S (i.e., skilled, bassinet) or denied.

10-010.11C Surveillance and Utilization Review of Hospital Outpatient Services: Claims for payment for hospital outpatient services are subject to review by the Department or its designee. Hospital outpatient care must be reasonable and medically necessary, and must be provided in the most appropriate place of service.

10-010.11D Billing the Client: When an individual is admitted to a hospital as a non-Medicaid patient and is later determined to be eligible for NMAP, the hospital shall not bill the client for services that are covered by NMAP. If the services are covered by NMAP but have been denied based on medical necessity, the provider shall not bill the client. The hospital may bill the client for those services that are specifically not covered by NMAP, such as cosmetic surgery.
10-011 Billing Requirements: Providers of hospital services shall submit claims to the Department on Form CMS-1450 see 471-000-51. Also see 471 NAC 3-003, Medicare/Medicaid Claims. Instructions for completing Form CMS-1450 have been published in the Nebraska Uniform Billing Data Element Specifications manual published by the Nebraska Uniform Billing Committee. Providers may purchase copies from the Nebraska Association of Hospitals and Health Systems. Providers using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) shall refer to the Claim Submission Table at 471-000-49.

10-011.01 Medicare Coverage: For a Medicare/Medicaid client, the provider shall bill Medicare for appropriate benefits before submitting a claim to Medicaid. (Exception: Medicare non-covered services covered by Medicaid).

10-011.02 Medicare Part B: If the Medicare/Medicaid client has exhausted his/her Medicare Part A benefits, the hospital shall bill these services or items to Medicare Part B if the client is covered by Part B before billing the Department. The hospital shall enter the amount approved by Medicare as a “prior payment” on Form CMS-1450 see 471-000-51 on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

10-011.03 Documentation: The Department requires that documentation when required, be submitted with each claim for hospital services. Documentation must be complete and legible.

Note: All Nebraska Medicaid Program clients sign a release of information statement when they apply for Medicaid. If the hospital requires another release, the hospital must obtain that release, based on the provider agreement with the Department.

10-011.04 Hospital-Acquired Conditions (HAC): Effective for inpatient and inpatient crossover claims with a ‘From’ date of service on or after the effective date of this regulation, hospitals are required to report whether each diagnosis on a Medicaid claim was present at the time of patient admission, or present on admission (POA). Claims submitted without the required POA indicators will be denied.

For claims containing diagnoses that are identified by Medicare as Hospital-Acquired Conditions, other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients and for which the condition was not POA, these diagnoses will not be used for AP-DRG grouping. The claim will be paid as though any diagnoses included in the list of HACs were not present on the claim. The Department does not make additional payments for services on inpatient hospital claims that are attributable to HACs and are coded with POA indicator codes “N” or “U”. Specifically, for hospitals paid under the:

1. Diagnostic related group (DRG) payment method, the Department does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).

2. Cost to Charges (CCR) payment method, the Department does not pay for charges attributable to the HAC.
3. Per Diem payment method, the Department will limit provider payment reductions to the extent that the identified PPC would otherwise result in an increase in payment, or if Medicaid can reasonably isolate for nonpayment the portion of the payment directly related to the PPC.

The Department denies payment for any HAC that results in death or serious disability.

10-011.04A Other Provider Preventable Condition (OPPC): Effective for inpatient, inpatient crossover, outpatient and outpatient hospital claims with a 'From' date of service on or after the effective date of this regulation, payment will be denied for the following Other Provider Preventable Conditions:

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

10-012 Hospital Utilization Review (UR): Each hospital must have in effect a utilization review plan that provides for review of services provided by the hospital and by members of the medical staff to Medicaid patients.

10-012.01 Composition of the Utilization Review Committee: A UR committee consisting of two or more practitioners must carry out the UR function. At least two members of the committee must be doctors of medicine or osteopathy. The other members may be -

1. A doctor of medicine or osteopathy;
2. A doctor of dental surgery or dental medicine;
3. A doctor of podiatric medicine;
4. A doctor of optometry; or
5. A chiropractor.

10-012.01A UR Committee: The UR committee must be -

1. A staff committee of the institution; or
2. A group outside the institution established by the local medical society and some or all of the hospitals in the locality or established in a manner approved by CMS.
If, because of the small size of the institution, it is impossible to have a properly functioning staff committee, the UR committee must be established under item 2 above.

The committee’s or group’s reviews may not be conducted by any individual who has a direct financial interest in that hospital or was professionally involved in the care of the patient whose case is being reviewed.

10-012.02 Scope and Frequency of Reviews: The UR plan must provide for review of Medicaid patients with respect to the medical necessity of -

1. Admissions to the hospital;
2. The duration of stays; and
3. Professional services provided, including drugs. Review of admissions may be performed before, at, or after hospital admission. Except for extended stay reviews under 471 NAC 10-012.04, reviews may be conducted on a sample basis.

Review of admissions may be performed before, at, or after hospital admission. Except for extended stay reviews under 471 NAC 10-012.04, reviews may be conducted on a sample basis.
10-012.03 Determinations Regarding Denial of Medical Necessity of Admissions or Continued Stays: The determination that an admission or continued stay is not medically necessary -

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

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

See 471 NAC 10-010.11 ff. regarding medical review activities.

10-012.03A Billing the Client: It is not a violation of NMAP's policy for the hospital to bill the client for services provided after the date the client receives notification if the following criteria are met:

1. The hospital's utilization review committee has determined that an admission or an extended stay is/was not medically necessary;
2. The hospital has met the client notification requirements in 471 NAC 10-012.03; and
3. The NMAP (Medicaid) client chooses to remain in the hospital or be admitted to the hospital.

10-012.04 Extended Stay Review: The UR committee must make a periodic review as specified in the UR plan of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling or the periodic reviews may be the same for all cases or different for different classes of cases.

10-012.05 Review of Professional Services: The UR committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

10-012.06 Recertification of Continued Stay: Recertifications must be made at least every 60 days after initial certification. Exception: Psychiatric inpatient care must be certified every 30 days under 471 NAC 20-001.07.
10-013 Medical Records: The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

10-013.01 Organization and Staffing: The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentification and protects the security of all record entries. Medical records must be retained in their original or legally reproduced form for a period of five years.

The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

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

10-013.02 Content of Record: The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

The author of each entry must be identified and must authenticate his/her entry.

Authentication may include signatures, written initials, or computer entry.

All records must document the following, as appropriate:

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

10-014 Swing Beds: NMAP covers only skilled nursing care (client requires 24-hour professional nursing care) for swing beds. Also see 471 NAC 12-008.08 ff. Swing bed services are services that meet the requirements of 42 CFR 483, Subpart B. Nursing or rehabilitation services which must be provided by or under the direct supervision of professional or technical personnel and require skilled knowledge, judgment, observation, and assessment may include, but are not limited to, the following:

1. Orally administered medications which require changes in dosage due to undesirable side effects or reactions, e.g., anticoagulants, Quinidine, etc. These must be administered to the patient by licensed nurses;
2. Frequent intravenous or intramuscular injections, except self-administered types such as insulin for a well-regulated diabetic;
3. Narcotics and controlled substances used on a p.r.n. (as circumstances may require) basis. Care relative to these substances must be documented in nurses' notes and physicians' orders with progress notes which contain observations made of the physical findings, new developments in the disease cause, how the prescribed treatment was implemented, and the resultant effects of the treatment;
4. Supplementation of physician care when -
   a. Uncontrolled or unstable medical conditions exist; and/or
   b. Observations of and instructions to the patient are needed relative to critical complications and evaluation of progress;
5. Initial phases of a medical regimen involving the administration of medical gases as directed by physicians' orders;
6. Physician-ordered restorative procedures which, because of the type of procedure or the patient's condition, must be performed by or under the direct supervision of the appropriately qualified therapist as defined in 42 CFR 483.45 (Note: Maintenance therapy is not skilled nursing care);
7. Colostomy or ileostomy care during the post-operative period until routine care is established;
8. Frequent catheterization or indwelling catheter care: urinary, bile ducts, chest, etc., or in combination with other skilled services;
9. Application of aseptic dressings and treatments (i.e., wound, tracheostomy care);
10. Nasopharyngeal aspiration and throat suctioning;
11. Levine tube and gastrostomy feedings; and
12. Decubitus ulcers - Stage III or IV.

The requirements of PASARRP and resident assessment (MDS) do not apply to swing beds.

10-014.01 Standards for Participation: To participate in Medicaid as a provider of swing-bed services, the hospital must be certified as a Medicare swing-bed facility by the Nebraska Department of Health and Human Services, Division of Public Health.

10-014.02 Provider Agreement: To be approved by the Department as a swing-bed provider, the hospital shall complete and sign Form MC-20. The agreement must be submitted to and approved by the Department. If the hospital has an approved agreement with the Department, it is not necessary to complete another Form MC-20 to provide swing-bed services.

10-014.03 Prior Authorization: To obtain prior authorization for payment for a client admitted to a swing bed, facility staff shall within 15 days of the date of admission to the swing bed -

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C or use the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);
2. Submit a copy of Form DM-5 or physician’s history and physical;
3. Complete Form DM-5LTC, “Long Term Care Evaluation;” and
4. Submit all the information to the local office.

10-014.04 Payment: Medicaid pays for swing-bed services at the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

To bill Medicaid for swing-bed services, the hospital shall use Form MC-4, “Long Term Care Facility Turnaround Billing Document” (see 471-000-82) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). If Medicare is covering the swing-bed services, the facility shall bill according to Medicare instructions.

When the client no longer requires a skilled level of care, Medicaid may authorize payment for up to five working days of care, when necessity to facilitate transfer to the appropriate level of care.
10-014.05 Ancillary Services: If the hospital bills for swing bed services on Form MC-4, the hospital shall bill as follows for ancillary services for swing-bed patients who are eligible for Medicaid only. If Medicare is covering the swing-bed services, the facility shall not bill NMAP for ancillary services.

Laboratory, radiology, respiratory therapy, physical therapy, occupational therapy, and speech pathology and audiology services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as outpatient services. These payment must be reported on the Medicare cost report as outpatient revenues.

Drugs must be billed via NE-POP by a licensed pharmacy. "Drug room" services cannot be billed separately.

Medical supplies are included in the rate for swing-bed services. Durable medical equipment and oxygen that are not considered part of the swing-bed service must be billed by the supplier. See 471 NAC 12-008.05, 12-008.06, 12-011.04B, and 12-011.04C regarding what is considered part of the per diem and what must be billed by the supplier.
CHAPTER 11-000  INDIAN HEALTH SERVICE (IHS) FACILITIES

11-001  Definitions

Encounter: A face-to-face visit, including telehealth services provided in accordance with 471 NAC 1-006, between a health care professional and an individual eligible for the provision of medically necessary Medicaid-defined services in an IHS or Tribal (638) facility within a 24-hour period ending at midnight, as documented in the client’s medical record.

Indian or Indians: An individual who meets any of the definitions in 25 U.S.C. §§1603(3), 1603(13), and 1679, or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. §§136.1 and 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization – I/T/U) or through referral under Contract Health Services (25 U.S.C §1603(5)).

Indian Health Service (IHS): An agency within the United State Department of Health and Human Services, which is responsible for providing federal health services to American Indians and Alaska Natives.

IHS Provider: A health care program, including contract health services (25 U.S.C §1603(5)), operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined 25 U.S.C. §1603. This includes Hospitals, Hospital Based Facilities, Pharmacies and outpatient clinics.

IHS Supplier: A freestanding (non-hospital based) entity that furnishes durable medical equipment, prosthetics, orthotics, supplies, and parenteral or enteral nutrition.

IHS Physician or Practitioner: Physician and non-physician practitioners billing for services under Medicaid.

11-002  Provider Requirements

11-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), IHS facilities shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 11, the individual provider participation requirements in 471 NAC Chapter 11 shall govern.

11-002.02 Service Specific Provider Requirements: Medicaid accepts IHS facilities as Medicaid providers on the same basis as other qualified providers. The facilities shall meet all applicable standards for licensure by the Nebraska Department of Health and Human Services, Division of Public Health (Licensure Unit), but need not be licensed. The absence of Nebraska licensure of
any staff member of an IHS facility may not be regarded as failure to meet the standards for licensure of the facility, so long as that member is licensed in another state. The Department verifies the Indian Health Service facility status by contacting the appropriate Indian Health Service area office.

11-002.02A  Provider Agreement: An Indian Health Service facility shall submit to the Department (Medicaid) Form MC-19, "Medical Assistance Provider Agreement," (See 471-000-91) and Form CMS-1539, "Medicare/Medicaid Certification and Transmittal," (see 471-000-66). Medicaid must approve enrollment before making payment to the IHS facility. A non-hospital-based provider who has met the Nebraska Department of Health and Human Services Regulation and Licensure standards shall submit to the Department Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90). Medicaid must approve enrollment before making payment to the provider.

11-002.02B  Compliance with Provider Requirements: In addition to the limitations and requirements outlined in this 471 NAC Chapter 11, IHS Providers shall comply with all applicable limitations in 471 NAC Chapters 1, 2 and 3, and all requirements outlined in each applicable service specific chapter in Title 471 of the Nebraska Administrative Code. As an example, IHS Providers of Dental Services must comply with both provider and service delivery limitations and requirements outlined in 471 NAC Chapter 6. IHS Providers of Pharmacy Services must comply with both provider and service delivery limitations and requirements in 471 NAC Chapter 16. These requirements apply to all services provided by IHS providers under the provisions of this 471 NAC Chapter 11.

11-003  Service Requirements

11-003.01  General Requirements

11-003.01A  Eligibility: Medically necessary services will be made available to any Indian, as that term is defined herein, who is also determined to be eligible for Medicaid in accordance with Title 477 of the Nebraska Administrative Code.

11-003.01B  Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

11-003.01C  HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

11-003.01D  Copayments / Cost Sharing: American Indians or Alaskan Natives who are eligible for, and have received, Medicaid covered services from an IHS or Tribal (638) facility shall be exempt from all copayment and cost sharing obligations.

11-003.02  Covered Services

11-003.02A  Scope of an Encounter: An encounter includes:

1. A practitioner visit which may be a:
   a. Physician, doctor of osteopathy, physician assistant, nurse practitioner, or certified nurse midwife;
b. Dentist;
c. Optometrist;
d. Podiatrist;
e. Chiropractor;
f. Speech, audiology, physical or occupational therapist;
g. Mental health provider such as a psychologist, psychiatrist, licensed mental health practitioner, certified drug and alcohol counselor, or a certified nurse practitioner providing psychotherapy or substance abuse counseling or other treatment with family and group therapy; or,
h. Pharmacist.

2. Diagnostic services such as:
   a. Radiology;
b. Laboratory;
c. Psychological testing; or,
d. Assessment (mental health)

3. Supplies used in conjunction with a visit such as dressings, sutures, etc.;
4. Medications used in conjunction with a visit such as an antibiotic injection; and,
   5. Prescribed drugs dispensed as a part of the encounter.

11-003.02B Encounters: Visits with more than one health professional, and multiple visits with the same health professional, that take place during the same day within the IHS or Tribal (638) facility constitute a single encounter.

11-003.02B1 Exceptions:
   a. When the patient is seen in the clinic, or by a health professional, more than once in a 24-hour period for distinctly different diagnosis. Documentation must include unrelated diagnosis codes;
   b. When the patient must return to the clinic for an emergency or urgent care situation subsequent to the first encounter that requires additional diagnosis or treatment;
   c. When a patient requires a pharmacy encounter in addition to a medical health professional or mental health encounter on the same day. Medicaid covers only one pharmacy encounter per day; or,
   d. When the patient is seen in the clinic by a clinical social worker or psychologist for a mental health encounter in addition to a medical health professional encounter on the same day.

11-003.03 Non-Encounter Services: Services rendered outside the office setting, office services that do not meet the criteria for the encounter, non-IHS Facility services, pharmacy services that are not provided by a designated tribal pharmacy or pharmacist, or services provided to non-American Indian or non-Alaskan Native clients. Examples of non-encounter services include, but are not limited to: Inpatient hospital visits, home and nursing facility visits, home health visit, durable medical equipment, ambulance, brief visit with nurse for blood pressure check or telephone consultations.
11-004 Billing and Payment for IHS or Tribal (638) Facility Services

11-004.01 Billing

11-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that individual billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 11, the individual billing requirements in 471 NAC Chapter 11 shall govern.

11-004.01B Specific Billing Requirements: The hospital-based facility shall submit all claims for payment for services to Medicaid clients on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). Non-hospital-based providers shall use the appropriate claim form or electronic format (see Claim Submission Table at Appendix 471-000-49). All IHS Providers shall comply with applicable billing instructions in Appendix 471-000-62.

11-004.01B1 Non-Encounter Charges: IHS Providers may provide services outside of those that meet encounter criteria. Services covered by Medicaid, but not considered eligible for encounter reimbursement, are to be billed on Form CMS-1500 using the appropriate HCPCS codes and will be paid according to the Nebraska Practitioner Fee Schedule.

11-004.01B2 Outpatient Encounter Charges: The Indian Health Service shall bill all outpatient encounter charges provided on the same day for the same Medicaid client as one outpatient charge per day.

11-004.01B3 Inpatient Charges: The Inpatient hospital per diem rate for inpatient medical care provided by IHS facilities is published annually in the Federal Register or Federal Register Notices. In order to receive the inpatient hospital per diem rate, the IHS or Tribal 638 facility must:
   a. Be enrolled as a provider with Medicaid; and
   b. Appear on the IHS maintained listing of IHS-operated facilities and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list

11-004.01B4 Utilization Review: All IHS Provider claims for payment are subject to appropriate claim edits and to surveillance and utilization review upon entry into the claims processing system. The hospital utilization review abstract/summary may be requested by Department staff.

11-004.02 Payment

11-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that individual payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 11, the individual payment regulations in 471 NAC Chapter 11 shall govern.
11-004.02B Specific Payment Requirements:

11-004.02B1 Reimbursement: IHS or Tribal (638) facilities will be paid at the most current encounter rate established by the IHS which is published annually in the Federal Register for established services provided in a facility that would ordinarily be covered services through the Nebraska Medicaid Program. Medicaid reimburses IHS facilities for inpatient and outpatient services at the Medicare/Medicaid rates established by the federal Department of Health and Human Services (DHHS).

11-004.02B2 Rate Methodology: Rate changes are effective the first day of the month following the Department’s receipt of the Medicare Interim Rate Notice, and will be applied retroactively to the federal effective date. Because specific Medicare/Medicaid rates are used and there is 100 percent federal match of these costs, Medicaid will not make an end-of-year settlement for Indian Health Service facilities.
CHAPTER 12-000 NURSING FACILITY SERVICES

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

12-001.01 Purpose

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

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

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

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

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

1. A determination whether the individual has mental illness, mental retardation or a related condition, or a dual diagnosis;
2. A determination whether the level of services provided by a nursing facility is appropriate to meet the individual's needs; and
3. A recommendation for services that addresses the individual's need(s) in a nursing facility or in an alternative placement (without regard to the availability of services).
12-001.02 Legal Basis: The Nebraska Medical Assistance Program (NMAP) was established under Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Section 68-1018, R.R.S. 1943.

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

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

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

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

Acute Medical Hospital: An institution that -

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

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

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

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

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

3. Provides 24-hour, seven-day week RN and/or LPN services (full-time R.N. on day shift) unless the Nebraska Department Health and Human Services Regulation and Licensure has issued a staffing waiver (see definition of "waivered facility" in 471 NAC 12-001.04); and

4. Has a current NMAP provider agreement and a Certification and Transmittal (Form HCFA-1539) on file with the Department.

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

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

2. Is certified as a Title XVIII SNF under Medicare (may also be certified as a Title XIX NF under Medicaid).

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

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

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

Admission means an admission applies to an individual who -

1. Has never resided in the nursing facility;

2. Has been formally discharged from one nursing facility and is being admitted to a different facility; or

3. Has been formally discharged, return not anticipated from a previous stay, by the admitting facility.

Each admission as defined above requires a new prior authorization.

For prior authorization purposes, NF to NF transfer is considered a new admission and requires a new prior authorization. For admissions that require preadmission screening under PASP, see 471 NAC 12-004.
Advance Directive is a written instruction, such as a living will or power of attorney for health care, recognized under State law (statutory or as recognized by the courts of the State) that relates to the provision of medical care if the individual becomes incapacitated.

Alternative Services means living arrangements providing less care than NF, ICF/MR, IMD, or inpatient psychiatric hospital, and more than independent living, such as adult family home, board and room, or assisted living.

Appropriate means that which best meets the client's needs in the least restrictive setting.

Bedholding means reimbursement made to a facility to hold a bed when a client is hospitalized and return is anticipated or on therapeutic leave.

Brain Injury means any level of injury to the brain often caused by an impact with the skull. Mild symptoms include persistent headaches, mood changes, dizziness, and memory difficulties. Severe head injury symptoms are more obvious: loss of consciousness; loss of physical coordination, speech, and many thinking skills; and significant changes in personality.

1. Acquired Brain Injury (ABI): An injury to the brain that has occurred after birth and which may result in mild, moderate, or severe impairments in cognition, speech-language communication, memory, attention and concentration, reasoning, abstract thinking, physical functions, psychosocial behavior, or information processing.
2. Traumatic Brain Injury (TBI): An injury to the brain caused by external physical force and which may produce a diminished or altered state of consciousness resulting in an impairment of cognitive abilities or physical functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychological maladjustment.

Further definition of Brain Injury for both TBI and ABI are clarified as acute or chronic.

1. Acute Brain Injury means the injury or insult occurred two years or less from the date of admission to the current extended brain injury rehabilitation program as described in 471 NAC 12-014.01B.
2. Chronic Brain Injury means an insult or injury that occurred more than two years before admission to the current extended brain injury rehabilitation program as described in 471 NAC 12-014.01B.

Categorical Determinations means advance group determinations under PASP that take into account that certain situations, diagnoses, or levels of severity of illness clearly indicate that admission to or residence in a nursing facility is needed, exempting the client from a Level II evaluation for a specified period of time. These determinations must be based on current documentation, such as hospital/physician report, etc. (See 471 NAC 12-004.07.)

Central Office means the Medicaid Division in the Nebraska Department of Health and Human Services and other staff in Health and Human Services to whom administration of the Medicaid program has been delegated.

Certified Facility means a facility which participates in the Medicaid program, whether that entity comprises all or a distinct part of a larger institution.

CMS means centers for Medicare and Medicaid Services (the federal agency previously known as HCFA).
Community-Based Developmental Disability Services (CBDDS) means an array of services for persons with mental retardation or a related condition, including vocational, pre-vocational, residential, and case management services, provided outside an institutional setting.

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

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

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

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

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

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

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

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

HCFA means health Care Financing Administration. Note: HCFA has been renamed and is now known as Centers for Medicare and Medicaid Services (CMS).
Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities means an array of community-based services available to individuals who are eligible for NF (Nursing Facility) services under the Nebraska Medical Assistance Program but choose to receive services at home. The purpose of the waiver services is to offer options to Medicaid clients who would otherwise require NF services.

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

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

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

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

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

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

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

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

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

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

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

Medicaid-Eligible means the status of a client who has been determined to meet established standards to receive benefits of Medicaid.
Medical Review means Program Specialist/R.N.‘s located in the Medicaid Division, Central Office, with physician consultation.

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

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

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

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

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

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

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

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

Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
Neurological Examination: For purposes of PASP, a neurological examination may consist of the following components:

1. Mental status exam. A mental status exam usually contains the following components:
   a. Appearance - age, grooming, posture, motor activity, stature (height and weight).
   b. General behavior - cooperative, withdrawn, apathetic, suspicious, aggressive, compliant, histrionic, anxious, relaxed, hostile.
   c. Affect and Mood - appropriate, flat, labile, sad, elated, angry, inappropriate.
   d. Thought Processes - logical, circumstantial, dissociated, obsessive, phobic, suicidal, flight of ideas, ideas of reference.
   e. Perception - illusions, hallucinations, delusions.
   f. Cognitive Functions - level of awareness (orientation to time, place, and person), attention and concentration, memory (remote and recent), judgment and insight.

2. Client's muscle strength and movements.
3. Pupillary reaction in terms of time and uniformity.
4. Coordination and balance.
5. Sensory abilities.
6. Lumbar and cisternal punctures as needed to detect blockage or central nervous system infection - such as meningitis, syphilis, or multiple sclerosis.
7. Myelography to diagnose a tumor, herniated disc, or other cause of nerve or spinal cord compression.
8. Brain scans and CT scans to discover causes of difficulties thought to be of cerebral origin.
9. Angiography to determine cause of motor weakness, stroke, seizure or intractable headaches.
10. EEG to detect brain tumors, infections, dementias and information concerning the cause and type of seizure disorder.
11. Electromyography to assist in diagnosing muscular dystrophy and myasthenia gravis or polyneuropathy.

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

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

OCMH means office of Community Mental Health.

PASP means preadmission Screening Process, required by the Social Security Act.
Physician's Certification means the physician's determination that the client requires the nursing facility level of care.

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

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

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

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

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

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

1. Type of test(s) administered to determine IQ score and adaptive behavior functioning;
2. Test scores;
3. Interpretation of the findings;
4. Recommendation;
5. Diagnosis;
6. Discussion of any other diagnosis and tests used to substantiate these findings; and
7. Summary of adaptive and functional levels.
Psychologist means for PASP purposes, the psychological evaluation must be completed by a psychologist who meets one of the following criteria:

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

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

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

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

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

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

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

Related Condition means an individual is considered to have a related condition, as defined by 42 CFR 435.1009, when the individual has a severe, chronic disability that meets all of the following conditions:
1. It is attributable to -
   a. Cerebral palsy or epilepsy; or
   b. Any other condition, other than mental illness, found to be closely related to
      mental retardation because this condition results in impairment of general
      intellectual functioning or adaptive behavior similar to that of persons with
      mental retardation and requires treatment or services similar to those required
      for these persons;
2. It is manifested before the person reaches age 22;
3. It is likely to continue indefinitely;
4. It results in substantial functional limitations in three or more of the following areas of
   major life activity:
   a. Self-care;
   b. Understanding and use of language;
   c. Learning;
   d. Mobility;
   e. Self-direction;
   f. Capacity for independent living.

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

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

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

1. Diagnosis Qualifier: The individual has a psychiatric diagnosis which, by accepted
   clinical standards, is determined to be a serious and persistent psychiatric condition,
   diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 4th
   Edition or its revisions. The mental disorder must be characterized as likely to lead
   to a chronic disability but cannot be a primary psychiatric diagnosis of dementia or a
   related disorder. For the purpose of this definition, Alzheimer's and organic
   disorders are considered related disorders to dementia. If dementia or a related
   disorder co-exists with a serious and persistent mental illness which is not a
   dementia, the dementia or related disorder must be predominant and progressive to
   exempt the co-occurring psychiatric condition from this qualifier.
In circumstances of co-occurring primary dementia and a serious mental illness, federal language requires that a reasonable effort must be made by the Level I screening agency to confirm the dementia as predominant and primary. Confirmation can occur through provision of appropriate testing (i.e., CT scans) and/or assessments (e.g., neurological, neuro-psychiatric) and/or mental status data which confirms the primary ranking of the dementing condition. Social history information, physician notes, etc., can also be used if the information supports a "reasonable effort" and effectively confirms the positioning of that diagnosis.

2. Disability/Level of Impairment Qualifier: Within the past six months, the psychiatric disorder has resulted in functioning limitations in one or more of the following major life activities on a continuing or intermittent basis:
   a. Serious difficulty interacting appropriately and communicating effectively with other persons. Examples of such difficulty may include but are not limited to possibly history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation;
   b. Serious difficulty sustaining focused attention for a sufficient period of complete tasks for which s/he should be medically capable. Examples of such difficulty may include but are not limited to concentration difficulties, inability to complete simple tasks within an established time frame, frequent errors related to task completion, or need for assistance in completion of tasks; or
   c. Serious difficulty adapting to typical changes in circumstances. Examples of such difficulty may include but are not limited to agitation, exacerbated signs and symptoms of the psychiatric condition, withdrawal from the situation, or need for intervention by the mental health or judicial system.

3. Duration/Recent Treatment Qualifier: The treatment history indicates that the individual has experiences at least one of the following:
   a. Psychiatric treatment more intensive than outpatient care (e.g., partial hospitalization, inpatient psychiatric hospitalization, crisis unit placement) once within the past two years for a nursing facility resident or more than once in the past two years for a nursing facility applicant.
   b. Within the past two years, due to the mental disorder, experienced a major episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials. For the purpose of this definition, major episode of significant disruption may include an involuntary psychiatric hospitalization, suicidal attempts or gestures, 1:1 monitoring, and/or other issues which are safety-related or involved.
   c. Residence in a nursing facility which provides intensive psychiatric services beyond that which is provided in a typical NF environment.
   d. Within the past two years, residence in a psychiatric hospital which required a period of hospitalization greater than that which is typically required for acute stabilization (e.g., inpatient psychiatric hospitalization extending beyond 30 days).
Specialized Services For Individuals with Mental Illness means services which result in the continuous and aggressive implementation of an individualized plan of care that -

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

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

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

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

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

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

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

With the exception of day program, these services are considered rehabilitative, rather than specialized, for these residents meeting medical necessity standards for nursing facility placement.
Status Change means a major change in the NF resident's status that -

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

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

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

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

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

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

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

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

Waivered Facility means a nursing facility that has received a waiver of licensed nursing staff requirements from the Department of Health and Human Services Regulation and Licensure.
12-002 Standards for Participation for Nursing Facilities:  The NF shall meet -

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

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

12-002.02 Nurse Aides

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

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

12-002.02B Facility Responsibility

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

1. The individual is a full-time employee currently participating in a training and competency evaluation program approved by the State; or
2. The individual can prove that s/he has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities shall follow up to ensure that the individual actually becomes registered.
12-002.02B2 Multi-State Registry Verification: Before allowing an individual to serve as a nurse aide, a facility shall seek information from every State nurse aide registry the facility believes will include information on the individual.

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

12-002.03 Nurse Aide Requirements

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

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

12-002.04 Establishment of Nurse Aide Registry

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

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

1. To be included on the nurse aide registry as eligible to function as a nurse aide, an individual shall meet the requirements in 471 NAC 12-002.02, including having no adverse findings of abuse, neglect, or misappropriation of property of a resident on the nurse aide registry;

2. An individual may be deemed or determined competent for eligibility for placement on the registry as provided in 42 CFR 483.150;

3. Adverse findings of abuse, neglect, or misappropriation of property are placed on the registry after a determination by the State survey and certification agency; and

4. No monetary charges related to registration of individuals on the registry are imposed.
12-002.04C  Registry Content: The registry contains the following information on each individual who has successfully completed a nurse aide training and competency evaluation program, or who has completed a competency evaluation and has been found to be competent to function as a nurse aide pursuant to 471 NAC 12-002.02:

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

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

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

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

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

1. The subject matter of the petition;
2. Employment history;
3. A signed release of information for employer references;
4. A statement indicating why the petitioner believes the findings of neglect should be removed from the registry;
5. Information regarding any education or rehabilitation efforts that the individual has completed since the finding of neglect was placed on the registry; and
6. Fee, as established by the State Patrol, for the State survey and certification agency to request a criminal background check.
12-002.04D2 Review of Petition: The State survey and certification agency will:

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

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

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

12-002.04D4 Notification:

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

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

12-002.05  Investigation of Complaints and Placement of Adverse Findings

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

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

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

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

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

1.  The nature of the allegation;
2.  The date and time of the occurrence;
3.  The right to a hearing;
4.  The survey and certification agency’s intent to report the substantiated findings in writing, once the individual has had the opportunity for a hearing, to the nurse aide registry or appropriate licensure authority;
5.  The fact that the individual’s failure to request a hearing in writing within 30 days from the date of the notice will result in the survey and certification agency reporting the substantiated findings to the nurse aide registry or appropriate licensure authority;
6.  The consequences of waiving the right to a hearing;
7.  The consequences of a finding through the hearing process that the alleged resident abuse or neglect, or misappropriation of resident property did occur; and
8.  The fact that the individual has the right to be represented by an attorney at the individual's own expense.
12-002.05C  Conduct of the Hearing and Judicial Review: The hearing is conducted under the following provisions:

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

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

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

1. The individual;
2. The current administrator of the facility in which the incident occurred;
3. The administrator of the facility that currently employs the individual, if different that the facility in which the incident occurred;
4. The licensing authority for individuals used by the facility other than nurse aides, if applicable; and
5. The nurse aide registry for nurse aides. The findings must be included in the registry within ten working days of the findings, in accordance with 471 NAC 12-009.03.
12-003 Client Classification for Nursing Facility Services

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

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

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

1. Activities of daily living (ADL) -
   a. Bathing: The ability to get to the bathing area and cleanse all parts of the body and the hair to maintain proper hygiene and prevent body odor, including tub, shower, and/or sponge bath.
   b. Continence: The control of one's body to empty the bladder and/or bowel on time; the ability to change incontinence pads/briefs, cleansing, and disposing of soiled articles; ability to manage ostomy equipment; ability to self-catheterize.
   c. Dressing/Grooming: The ability to put on and remove clothing as needed from both upper and lower body; the ability to do routine daily personal hygiene (combing hair, brushing teeth, caring for dentures, washing face and hands, and shaving).
   d. Eating: The ability to take nourishment. This may include the act of getting food from the plate to the mouth, and does not include meal preparation.
   e. Mobility: The ability to move from place to place indoors or outside.
   f. Toileting: The ability to get to and from the toilet, commode, bedpan, or urinal, including transfer to and from the toilet, management of clothing, and cleansing.
   g. Transferring: The ability to move from one place to another, including bed to chair and back, and into and out of a vehicle. (It does not include toilet transfer.)

2. Risk Factors -
   a. Behavior: The ability to act on one's own behalf, including the interest or motivation to eat, take medications, care for one's self, safeguard personal safety, participate in social situations, and relate to others in a socially-appropriate manner.
   b. Frailty: The ability to function independently without the presence of a support person, including good judgment about abilities and combinations of health factors to safeguard well-being and avoid inappropriate safety risk.
   c. Safety: The availability of adequate housing, including the need for home modification or adaptive equipment to assure safety and accessibility; the existence of a formal and/or informal support system; and/or freedom from abuse or neglect.
3. Medical Treatment or Observation
   a. A medical condition is present which requires observation and assessment to assure evaluation of the individual's need for treatment modification or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self-observe and/or evaluate the need to contact skilled medical professionals; or
   b. Due to the complexity created by multiple, interrelated medical conditions, the potential for the individual's medical instability is high or exists; or
   c. The individual requires at least one ongoing medical/nursing service. The following is a non-inclusive list of such services which may, but not necessarily, indicate need for medical or nursing supervision or care:
      (1) Application of aseptic dressing;
      (2) Routine catheter care;
      (3) Respiratory therapy;
      (4) Supervision for adequate nutrition and hydration due to clinical evidence of malnourishment or dehydration or due to a recent history of weight loss or inadequate hydration which, if unsupervised, would be expected to result in malnourishment or dehydration;
      (5) Therapeutic exercise and positioning;
      (6) Routine colostomy or ileostomy care or management of neurogenic bowel and bladder;
      (7) Use of physical (side rails, poseys, locked wards) and/or chemical restraints;
      (8) Routine skin care to prevent pressure ulcers for individuals who are immobile;
      (9) Care of small, uncomplicated pressure ulcers and local skin rashes;
      (10) Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;
      (11) Chemotherapy;
      (12) Radiation;
      (13) Dialysis;
      (14) Suctioning;
      (15) Tracheostomy care;
      (16) Infusion therapy;
      (17) Oxygen;
      (18) Open lesions other than stasis or pressure sores (e.g., cuts);
      (19) Wound care or treatment (e.g., pressure ulcer care, surgical wound);
      (20) Intravenous medications;
      (21) Transfusions;
      (22) Medication monitoring; and/or
      (23) Other special treatment or procedure.

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

The services coordinator may administer a standard mini-mental test, as appropriate, to further identify memory, orientation, and communication limitations. Additional exploration of judgment may also be necessary.
12-003.02A  Determining NF Level of Care: Services coordinators collect the above information on each individual seeking NF or waiver services to determine the functional abilities and care needs of that individual. Information may be gathered from a variety of sources (e.g., the individual, family, care providers, physicians, facility staff, case files, medical charts), using observation, documentation review, and/or interview until sufficient information is obtained to determine the individual's current functioning in each area.

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

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

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

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

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

Section A

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

Section B

B.1. Mental health needs do not require specialized services but may require mental health services as part of the overall plan of care, to include but not limited to services, such as medication monitoring, counseling and therapy, consultations with a psychiatrist, participation in activities.
B.2. Mental retardation/related condition needs to not require specialized services but may require rehabilitative services such as Physical Therapy, Occupational Therapy, Speech, social/recreational activities.
12-003.03 Mental Retardation/Related Conditions (MR/RC) Services in an NF: NF services may be provided to persons having a diagnosis of mental retardation or a related condition under the following conditions:

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

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

1. When medical conditions meeting the NF level of care (see 471 NAC 12-003.02) are the primary need of the client; and
2. Documentation of previous services and an assessment within the last year have determined that the individual's mental health needs can adequately be met within the NF level of care; and
3. The evaluation of appropriateness and adequacy of services is based on the information contained in Form HHS-OBRA9, "Summary of Findings" (see 471-000-231) with consideration of and incorporation of PASP recommendations in the client's comprehensive plan of care.
12-004 Preadmission Screening Process (PASP): When an individual requests admission to or continuous residence in a Medicaid-certified bed in a nursing facility, the facility shall implement the Preadmission Screening Process (PASP) as defined in this chapter. An individual who has an indication or diagnosis of mental illness, mental retardation or a related condition, or a dual diagnosis may be admitted to a nursing facility or continue to reside in a nursing facility only when the individual is determined to be appropriate for nursing facility services through the PASP.

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

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

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

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

12-004.02 Level I Evaluation:

1. A Preadmission Screening Process (PASP) for -
   a. All persons who have requested a Medicaid certified NF bed and who have been determined by the HHS/contractor to have mental illness (MI) and/or mental retardation (MR) or a related condition (RC) as defined under 471 NAC 12-004.05.
   b. Any request for a first time admission or readmission to a Medicaid certified NF for a resident who has been treated in an inpatient psychiatric setting or equally intensive service, e.g., crisis unit, and the HHS/contractor has determined that the individual qualifies for such preadmission review per criteria provided under 471 NAC 12-004.05.
2. The Status Change Process is required for all NF residents who -
   a. Have never been evaluated through the PASP process but have been determined to exhibit signs, symptoms, and/or behaviors suggesting the presence of a diagnosis of MI and/or MR/RC (as defined under 471 NAC 12-001.04).
   b. Have demonstrated an increase in symptoms and/or behaviors to the extent that there is a change in mental health and/or mental retardation treatment needs.
   c. Have demonstrated a significant physical status improvement such that s/he is more likely to respond to special treatment for that condition or s/he might be considered appropriate for a less restrictive placement alternative.
   d. Have required inpatient psychiatric treatment. A Level II status change is required prior to the individual's readmission to the facility.
   e. Have been approved for NF stay for a short term period and the individual's stay is expected to exceed the approved time frame.

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

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

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

Medicaid pays for nursing facility stays for Medicaid-eligible clients under the exempted hospital discharge provision only when the HHS-OBRA1, indicating the exempted hospital discharge, accompanies the prior authorization request.
12-004.03A  Level I Evaluation: A Level I Screen is required for any individual who:

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

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

1. Negative Screens - For ID screens which are clearly negative, the referral source must submit a copy of the HHS-OBRA1 to HHS Finance and Support Medicaid, and the HHS/Contractor. No verbal contact is required with the HHS/Contractor regarding that screen.
2. Questionable Screens - In cases where information suggests the possibility of a MI and/or MR/RC, the referral source must submit medical records information with the HHS-OBRA1 and HHS-OBRA1a, as applicable, to clarify the presence/absence of the suspected disorder. Examples of clarifying information include data specified under 471 NAC 12-004.08. When an individual's condition suggests that some but not all criteria are met to qualify as MI and/or MR/RC under the criteria provided in 471 NAC 12-004.05, the HHS/Contractor will exclude the individual from the PASP Level II process and will forward notification to the referral source indicating that any later status change suggesting full qualification for such a condition should be forwarded to the HHS/Contractor for consideration of Level II need.
3. Modified Level I Screens - In cases where the Level I review agent adds/modifies information presented on the Level I screen, changes and their rationale will be so noted on the protocol. A copy of the modified protocol will be forwarded to the Medicaid Division as well as to the referring facility by the Level I screening agency. The modified HHS-OBRA1 protocol must be maintained in the individual's permanent medical record.
4. Exempted Hospital Discharges and Categorical Determination (OBRA1a) - Requests for exemptions or categorical decisions must include supportive documentation. Both the Exempted Hospital Discharge provision and the categorical determination options allow the individual to be admitted to a nursing facility without requiring performance of an on-site Level II evaluation. The options are indicated on the OBRA1a and offer either short term approvals or categorical approvals based upon certain presenting circumstances. Short term options allow for only brief admission, whereby further contact must be made with the HHS/contractor to initiate re-screening through the Level I and arrangements for the Level II if the individual’s stay is expected to exceed the approved time frame. Refer to 471 NAC 12-004.07 for an explanation of those determinations and applicable time frames.

5. Positive Level I Screen - The reviewing agent will request medical records information which sufficiently supports that the individual meets criteria for a PASP evaluation as indicated in 471 NAC 12-004.05A and B. If the individual is identified as potentially having MR/RC, the Level I review agency will additionally request information regarding whether the presence of MR has been clinically diagnosed through psychological testing.

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

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

12-004.05 Identification Criteria

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

1. Diagnosis Qualifier: The individual has a psychiatric diagnosis which, by accepted clinical standards, is determined to be a serious and persistent psychiatric condition, diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition or its revisions. The mental disorder must be characterized as likely to lead to a chronic disability but cannot be a primary psychiatric diagnosis of dementia or a related disorder. For the purpose of this definition, Alzheimer's and organic disorders are considered related disorders to dementia. If dementia or a related disorder co-exists with a serious and persistent mental illness which is not a dementia, the dementia or related disorder must be predominant and progressive to exempt the co-occurring psychiatric condition from this qualifier.
2. Disability/Level of Impairment Qualifier: Within the past six months, the psychiatric disorder has resulted in functional limitations in one or more of the following major life activities on a continuing or intermittent basis:
   a. Serious difficulty interacting appropriately and communicating effectively with other persons. Examples of such difficulty may include but are not limited to, possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation;
   b. Serious difficulty in sustaining focused attention for a sufficient period to complete tasks for which s/he should be medically capable. Examples of such difficulty may include but are not limited to concentration difficulties, inability to complete simple tasks within an established time period, frequent errors related to task completion, or need for assistance in completion of tasks; or
   c. Serious difficulty adapting to typical changes in circumstances. Examples of such difficulty may include but are not limited to agitation, exacerbated signs and symptoms of the psychiatric condition, withdrawal from the situation, or need for intervention by the mental health or judicial system.

3. Duration/Recent Treatment Qualifier: The treatment history indicates that the individual has experienced at least one of the following:
   a. Psychiatric treatment more intensive than outpatient care (e.g., partial hospitalization, psychiatric inpatient care, crisis unit placement) once within the past two years for a nursing facility resident or more than once in the past two years for a nursing facility applicant; or
   b. Within the last two years, due to the mental disorder, experienced a major episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. For the purpose of this definition, major episode of significant disruption may include an involuntary psychiatric hospitalization, suicidal attempts or gestures, 1:1 monitoring, and/or other issues which are safety-related or involved.
   c. Within the past two years, residence in a psychiatric hospital which required a period of hospitalization greater than that which is typically required for acute stabilization (e.g., inpatient psychiatric hospitalization extending beyond 30 days).

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

1. The individual has a recent history (within the last two years) of a serious mental illness;
2. There is presenting evidence of a serious mental illness which includes possible disturbances in orientation, affect, or mood, and the primary psychiatric condition is not dementia, Alzheimer's disease or a related disorder. "Primary" means that the symptoms of the dementia supersede symptoms of any co-occurring psychiatric condition; and
3. The individual has been prescribed a psychoactive medication on a regular basis, expressly for the indicators identified above.
12-004.05A2 Dementia, Alzheimer’s Disease, or Related Disorder: An individual is considered not to require a PASP Level II psychiatric evaluation if dementia or a related disorder can be ranked as primary over any additional co-occurring psychiatric disorders, where present, and the dementing condition meets established clinical standards specified in the Diagnostic and Statistical Manual, Version IV. In circumstances of dementia which co-occurs with other physical conditions but is said to be the primary psychiatric disorder, the facility must make a reasonable effort as specified under 471 NAC 12-004.05A, diagnosis qualifier, to provide documentation to the HHS/contractor that the dementing condition is primary.

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

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

1. Suspicion or diagnosis of Mental Retardation (MR): An individual is considered to have mental retardation if s/he has a level of mental retardation (mild, moderate, severe, profound) as described in the American Association on Mental Retardation’s Manual or Classification in Mental Retardation (1983). Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period; and/or

2. Suspicion or presence of a Related Condition/Developmental Disability (RC): Related condition is defined as a severe, chronic disability whose condition is:
   a. Attributable to cerebral palsy or epilepsy; or any other condition, other than MI, found to be closely related to MR because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with MR and requires treatment or services similar to those required for such persons (i.e., autism);
   b. Manifested before the person reached age 22;
   c. Likely to continue indefinitely;
   d. Results in substantial functional limitations in three or more of the following areas of major life activity:
      (1) Self-care;
      (2) Understanding and use of language;
      (3) Learning;
      (4) Mobility;
      (5) Self-direction;
      (6) Capacity for independent living.

Note: In the absence of a known diagnosis of MR or a related condition, a suspicion (e.g., cognitive or adaptive limitations) or history of treatment by an agency serving individuals with such conditions should trigger the housing/receiving facility to contact the HHS/contractor for a determination of need for Level II evaluation under the PASP program.
12-004.06 Negative Screens: If a Medicaid-eligible client does not require a Level II evaluation and is admitted to the nursing facility, the facility shall -

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

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

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

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

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

2. Categorical Respite 30 Day - The individual is being admitted to provide respite care for a period not to exceed 30 calendar days for in-home caregivers to whom the individual is expected to return. Before admission can occur, documentation supporting the need for respite services placement must be provided along with Forms HHS-OBRA1 and HHS-OBRA1a to HHS/contractor. If it is determined that the individual's stay in the NF will continue beyond the approved 30-day time frame, the receiving facility must contact HHS/contractor as soon as the determination is made that continued stay will be required and no later than the 30th calendar day following admission, in order to arrange an on-site Level II evaluation.
3. Categorical Progressed Dementia with MR/RC: The individual has mental retardation or a related condition along with a co-occurring diagnosis of progressed dementia, Alzheimer's disease or related disorder. Both of the following must also be present: The diagnosis of dementia, Alzheimer's disease or related disorder must be considered the primary diagnosis and the individual must be considered to be in the advanced stages of this condition and no longer able to meaningfully participate in or benefit from a program of specialized services. Before admission can occur, medical records information which supports that the individual qualifies under this criterion must be provided to HHS/contractor along with Forms HHS-OBRA1 and HHS-OBRA1a.

4. Categorical Serious Medical - The individual's medical condition renders him/her unable to benefit from a plan of specialized services and clearly meets criteria for NF care. Applicable conditions include: Coma, Ventilator Dependence, Brain Stem Injury, End-Stage Medical Condition. In order to qualify, medical records information which support that the individual qualifies under this criterion must be provided along with Forms HHS-OBRA1 (see 471-000-223) and HHS-OBRA1a (see 471-000-226) to HHS/contractor before the individual's admission can occur.

5. Exempted Hospital Discharge - Federal regulations also offer an exemption from the Level II PASP process for individuals with mental illness and/or mental retardation/related conditions who meet Exempted Hospital Discharge criteria discussed in 471 NAC 12-004.03.

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

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

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

Note: Notification of approval under the Exempted Hospital Discharge provision will be forwarded to HHS F&S and the referring source along with Forms HHS-OBRA1, HHS-OBRA1A, and a notification letter (HHS-OBRA5) explaining provisions of the exemption.
12-004.07C Notice: Following the categorical determination, the HHS/contractor shall issue Form HHS-OBRA5 (see 471-000-227) prior to admission to:

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

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

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

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

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

1. Form HHS-OBRA8 (see 471-000-230) (signed Release of Information);
2. A Social History which contains current psychological information specified in the Guidelines for Social History found in 471-000-234. The Social History must be completed or countersigned by a social worker certified by the Department of Health and Human Services Regulation and Licensure;
3. One of the following:
   a. Form DM-5-LTC, “Long Term Care Evaluation” (see 471-000-222);
   b. Form “MDS2.0” (see 471-000-43);
   c. Form MC-75Q, “MDS2.0 Quarterly” (see 471-000-44); or
   d. Form MC9NF, “Prior Authorization for Nursing Facility Care” (see 471-000-203);

4. History and physical examination or a copy of Form DM-5 “Physician’s Confidential Report” (see 471-000-221); and

5. Guardianship certification, if applicable.

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

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

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

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

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

1. Whether the individual has mental illness and/or mental retardation/related condition as defined by federal regulations and as specified under 471 NAC 12-004.05A and 12-004.05B, respectively.
2. Whether the level of services provided by a NF or another institutional placement is appropriate to meet the individual's needs; and
3. For applicants determined to require NF placement and for all evaluated NF residents, services which are required to meet the evaluated individual's needs, including mental health services which are of lesser intensity than specialized services and are the responsibility of the receiving/retaining facility and/or specialized services which are the responsibility of the State.
12-004.09A  Returning From Receiving Specialized Services for Mental Illness: If an individual is returning to a nursing facility from receiving specialized services for mental illness, s/he requires a new Level I screen to determine further screening requirements. If the Level I screen indicates that the individual meets serious mental illness criteria as indicated in 471 NAC 12-004.05A, a Level II summary of findings report must be issued. The summary may be based upon a document-based review of the psychiatric facility’s medical records, if an on-site Level II assessment was performed within the 90-day period and current documentation supports that the individual is sufficiently stable. An on-site evaluation is required if an on-site Level II has not been performed within the prior 90-day period or if the documentation does not sufficiently indicate adequate psychiatric stabilization.

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

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

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

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

12-004.09E  Mental Health Evaluator Action: For each individual with an indication or diagnosis of mental illness, the evaluator shall complete Form HHS-OBRA2, "Evaluation and Service Recommendation (see 471-000-224)," which contains medical, functional, and psychosocial information. The on-site evaluation and the final validation and summary report must be completed by the seventh business day of the referral for an evaluation by the Level I screening agency to the on-site evaluator. Following completion of the on-site evaluation, evaluative data will be reviewed and countersigned by a board-eligible or board-certified psychiatrist who will: validate whether the individual has a mental illness (as defined in 471 NAC 12-004.05A), summarize the individual’s medical and social history, provide recommendations to meet the individual’s service needs, and provide recommendations regarding the individual’s placement needs.
12-004.09F Mental Retardation/Related Condition Evaluator Action: For each individual with an indication of mental retardation or a related condition, the evaluator will complete the on-site evaluation. The on-site evaluation and the final validation and summary report will be completed by the seventh business day of the referral for an evaluation by the Level I screening agency to the on-site evaluator. Intellectual testing and an adaptive behavior scale will be administered to establish a diagnosis if: testing performed within the past three years is not available; the individual is not currently or has not historically received services from a community-based provider; or the individual is not currently or was not historically placed in an ICF/MR.

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

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

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

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

12-004.09H Participation in the Level II Evaluation: The mental health and/or QMRP evaluator shall contact the retaining facility to coordinate the time and date of the on-site evaluation and to assure that the Form HHS-OBRA8 (see 471-000-230) has been or will be signed. If the individual has a legal representative, the facility shall notify the legal representative of the scheduled assessment time/date and invite him/her to participate. The family must likewise receive notification from the facility of the pending evaluation, if family is available and if the individual or his/her legal representative agrees to family participation.
12-004.09J Pre-Existing Data: Relevant evaluative data collected prior to the Level II evaluation may be used if the data is considered valid and accurate and it reflects the current functional status of the individual. To supplement existing data, the Mental Health Reviewer and/or QMRP shall gather additional information necessary to assess proper placement and treatment.

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

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

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

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

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

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

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

12-004.11D HHS F&S Action: The Department of Health and Human Services Finance and Support Medicaid Division shall maintain review outcome data along with other appropriate medical screening documentation for that individual.
12-004.11E Mental Health Evaluator Action: For each individual subject to the RR/SC, evaluator actions specified under 471 NAC 12-004.09E for PASP MI evaluations shall be completed.

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

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

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

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

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

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

12-004.12C Physician Letter: HHS/contractor shall notify the individual's physician by letter if the individual is inappropriate for NF services before issuing Form HHS-OBRA5 (see 471-000-227).
12-004.13 Notification of Final Determination: HHS/contractor shall make a final determination after reviewing the information obtained from the Level II evaluation and shall prepare an evaluative report of such findings. This report, HHS-OBRA9 (see 471-000-231), includes the following data elements -

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

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

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

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

1. The individual's attending physician;
2. The discharge hospital, if applicable;
3. The CMHR and/or CBDDSP for individuals with MI and/or MR/RC who are denied NF placement, determined to require specialized services, or for whom specialized services are/were discontinued as a result of the determination; and
4. The Department of Department of Health and Human Services Finance and Support Medicaid Division.
12-004.13A1 Assurances: Within one business day of the final PASP determination or an RR/SC determination made under 471 NAC 12-004.11C, HHS/contractor will contact the referring source to explain the results of the determination and to request that these results be conveyed to the individual or his/her legal representative. For all determinations resulting in adverse consequences to the individual (e.g., denial of NF placement, determination of community-based service needs, determination of specialized service needs), HHS/contractor shall make the verbal contact described above and shall refer the individual to the CMHR or CBDDSP for individuals with MI and MR/RC, respectively. The CMHR or CBDDSP will, in turn, arrange contact with the individual or legal representative to coordinate service and/or placement options.

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

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

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

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

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

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

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

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

Form HHS-OBRA9 represents the final determination and recommendations. The nursing facility shall incorporate all recommendations into the plan of care and update facility records with current diagnosis and other evaluation information.
12-004.13E  Choice:  Individuals who have resided in a nursing facility for 30 continuous months may elect continued NF residence if the PASP evaluation determines that nursing facility care is inappropriate but specialized services, which can be provided by the State in the nursing facility, as needed. The 30 months of continuous residence is calculated back from the first PASP determination which found that the individual was not in need of NF care. The initial choice provision and alternative placement options shall be explained by the CBDDSP or the CMHR, as appropriate.

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

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

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

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

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

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

The determination regarding the provision of services must be based upon standards governing the service-delivery program, not those found within this chapter.
12-004.15 Appeal Process: At the conclusion of each PASP evaluation, HHS/contractor shall issue written appeal rights and instructions for requesting a fair hearing, as defined under 42 CFR 431, Subpart E and 483, Subparts C and E. These allow the individual or legal representative to appeal any determination rendered through the PASP process which is felt to adversely affect the evaluated individual.

The individual or legal representative will be instructed to contact HHS/contractor for information on appeals and to forward a written request for an appeal to the Department of Health and Human Services Finance and Support within 90 days of the date of the PASP determination notice.
12-005. Senior Care Options (SCO): The Department of Health and Human Services Finance and Support (HHSFS) contracts with area agencies on aging (AAA) to operate SCO. The AAA, as Senior Care Options (SCO), is responsible for accurately determining the Nursing Facility (NF) level of care of each person evaluated and providing information about service options, as appropriate for the individual's situation. SCO may obtain information to be used in the evaluation decision from a variety of sources, including but not limited to observation; interview of older person, family members, nursing facility staff, hospital staff; and review of medical records. SCO is responsible for making the final decision.

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

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

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

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

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

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

9. Receive Medicaid services through a Medicaid managed care plan and enter the NF on a short-term basis (and will, therefore, continue with the managed care plan.) This does not apply to clients enrolled in a primary care case management under Medicaid managed care; they are appropriate for SCO evaluation; or

10. Are admitted to a bed covered by a special Medicaid contract (e.g., 471 NAC 12-014).

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

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

12-005.04 Referral

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

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

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

1. The name of the person making the referral, his/her position, and telephone number;
2. The name of the nursing facility involved, if different than the referral source;
3. The name, date of birth, and social security number of the person to be evaluated;
4. The date and time the referral is being made; and
5. Whether this is considered an emergency.
12-005.04C  Receiving Referrals: When the SCO counselor receives a referral to evaluate an applicant for admission to a nursing facility, s/he will begin to collect the information outlined on the evaluation form. Information may be collected either in person or through telephone interviews. If only telephone contact is used, two information sources are preferred. Based on the information gathered through the evaluation, the SCO counselor determines whether the applicant meets nursing facility level of care criteria.

12-005.04D  Evaluation Time Frames

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

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

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

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

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

12-005.04D3  After Pending Status: If a current NF resident applies for Medicaid without informing the NF and no SCO referral is made during the pending period, the NF must make an immediate referral to SCO when information is received that Medicaid has been approved. SCO shall perform an evaluation within 48 hours of the delayed referral and, if the following conditions are met, authorize payment for NF services retroactive to the first date of Medicaid eligibility:
1. The nursing facility has in place a process to inform private pay clients and their families that the NF must be informed when a Medicaid application is made.
2. The nursing facility makes a referral to SCO immediately upon receipt of information about the opening of the Medicaid case. At the time of this referral, the NF shall provide information on the date and means by which information about Medicaid eligibility was obtained.
3. The resident meets the NF level of care criteria.

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

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

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

Professional evaluation is appropriate when -

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

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

12-005.06 Outcomes of the Evaluation:

12-005.06A NF Level of Care Met: If the SCO counselor determines that the applicant meets nursing facility level of care criteria and the client chooses to receive NF services, the SCO counselor completes Form MC-9-NF (see 471-000-203) which authorizes Medicaid payment for nursing facility care.
12-005.06B  NF Level of Care Not Met: If the evaluation counselor determines that the applicant does not meet nursing facility level of care, the SCO counselor notifies the applicant of that determination. Persons who are found to be ineligible for Medicaid reimbursement for nursing facility service will be sent a notice of denial (Form DSS-6) (see 471-000-23) by the SCO counselor. A copy of the notice will be sent to the NF for clients currently eligible for Medicaid.

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

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

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

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

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

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

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

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

1. Information which indicates that the individual is eligible for evaluation through SCO;
2. Notations of information leading to findings;
3. A completed evaluation instrument;
4. Time lines of action from the time of referral to completion of screening and notification of findings.
12-005.08 Billing: Each Senior Care Options program site shall sign Form MC-19, "Medical Assistance Provider Agreement (see 471-000-90)," to establish their Medicaid case management provider status. The site may then bill HHS for screening activities. Information included in a billing document will include project site, client name, SSN, service month and year, date submitted, signature of authorized person unless submitted electronically, place of service, type of service, unit rate, and total charge.

Billing documents will be submitted to HHS for payment.

12-005.09 Notices and Appeals

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

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

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

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

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

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

If an appeal was filed within time frames following termination of NF services, Medicaid payment will be made according to the content of the Finding and Order.
12-006 Local Office Staff Responsibilities: Regulations in this section apply to clients not covered by the SCO.

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

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

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

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

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

Referrals: Local office staff shall refer any client or applicant age 65 or older to Senior Care Options for assessment when nursing facility care is requested.
12-006.02 Prior Authorization Requirements: NMAP shall pay for a nursing facility service only when prior authorized. Each admission must be separately prior authorized. See 471 NAC 12-001.04, definition of admission.

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

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

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

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

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

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

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

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

1. The nursing facility retains the original for the client's record and sends two copies to the local office;
2. Local office staff retain a copy in the client's case record; and
3. Local office staff send a copy to the Central Office.
12-006.03 Use of Form MC-10: Form MC-10 (see 471-000-211) adjusts (corrects, deactivates, or reactivates) the MC-9-NF payment authorization.

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

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

Scenarios:

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

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

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

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

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

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

A client expires in the Facility or in the case of a NF bedholding while in acute care in a hospital, the date the client expires in the hospital (if not over the 15 days of hospital bedhold)
*deactivate the date client expires
12-006.04 Facility-to-Facility Transfer: When a Medicaid client is transferred from one facility to another (NF or ICF/MR), the local office worker shall complete Form MC-10 (see 471-000-211) to close the prior authorization for the previous facility for the date of the transfer.

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

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

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

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

Time-limited authorizations exceeding 30 days may be made based on the client's potential for discharge as determined by the Medical Review.
12-007 Responsibilities of Nursing Facilities: Nursing facilities shall provide staff of the Department of Health and Human Services Finance and Support and its contractor, and staff of Department of Health and Human Services with the data, forms, and cooperation necessary to admit, plan for, evaluate the medical care needs of, and make determinations on the appropriateness of nursing facility services for each Medicaid client as required by the Nebraska Department of Health and Human Services Finance and Support Manual and federal Medicare and Medicaid regulations and program instructions. **Note:** The Department encourages both facility and local office staff to identify contact persons and to establish a working relationship with that contact person to facilitate timely communication.

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

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

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

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

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

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

If the client's level of care is determined to be "skilled," the Plan will be responsible for medical management of the Medicaid services the client requires. Arrangement for payment must be made with the HMO Managed Care Plans. If the level of care is determined to be "custodial," proceed with the current process for Department of Health and Human Services Finance and Support payment.
12-007.01A Admission of Managed Care Clients:

1. When a Medicaid-eligible, managed care client is admitted to a nursing facility, the Managed Care Plan in coordination with the Primary Care Physician (PCP) will determine the level of care the client requires - skilled/rehabilitative or custodial/maintenance using Medicare's definition for skilled care. When the level of care the client requires is skilled/rehabilitative, the client will not be disenrolled from managed care. The Plan will continue medical management of the client. The HMO Plans will be financially responsible for the skilled care service. Claims for a client enrolled in the Primary Care + Plan will be sent to the Department of Health and Human Services Finance and Support.

2. When the client is admitted to a nursing facility for custodial care, the Department of Health and Human Services Finance and Support will assume financial responsibility for the facility charges. The Plan will continue the medical management of the client for all services included in the basic benefit package. All services included in the basic benefit package will be the financial responsibility of the HMO Plans until disenrollment of the client from managed care. Claims for clients enrolled in Primary Care + Plan will be sent to the Department of Health and Human Services Finance and Support. Disenrollment from managed care will occur the first day of the month following the change in the living arrangement code. For changes in the living arrangement code entered the last five working days of the month, disenrollment will not occur until the beginning of the next month (current month + 1).

3. When the client is admitted to a nursing facility for "custodial" care and the client's primary care physician (PCP) does not see clients at the facility, the Plan will work cooperatively with the client and nursing facility staff to locate another physician for the client until disenrollment.

4. Clients residing in a nursing facility in an assisted living situation, at a domiciliary or room and board rate, are not residents of the nursing facility. These clients will not be disenrolled from managed care unless the Plan determines that a change in level of care is appropriate.

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

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

Note: For Senior Care Options preadmission, see 471 NAC 12-005.
12-007.02A  **Level I Evaluation:** The Level I Screen is required for any individual who -

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

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

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

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

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

**Note:** Senior Care Options staff will not reevaluate the level of care needs of a person transferring to a second nursing facility. However, SCO must be informed of the transfer to generate Form MC-9-NF (see 471-000-203) for the receiving NF.
12-007.02C Exempted Hospital Discharge Stays That Exceed 30 Days: If an individual who qualifies as an exempted hospital discharge is later found to require more than 30 days of nursing facility care, the nursing facility shall contact the HHS/contractor and shall send Form HHS-OBRA1 to HHS/contractor by the 30th day. If a Level II evaluation is indicated, the facility shall also send to the HHS/contractor by the 30th day with Form HHS-OBRA1:

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

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

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

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

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

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

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

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

2. Categorical Respite 30 Day - The individual is being admitted to provide respite care for a period not to exceed thirty (30) calendar days for in-home caregivers to whom the individual is expected to return. Before admission can occur, documentation supporting the need for respite services placement must be provided along with Forms HHS-OBRA1 and HHS-OBRA1a to HHS/contractor. If it is determined that the individual's stay in the NF will continue beyond the approved 30-day time frame, the receiving facility must contact the HHS-OBRA Unit or its contractor as soon as the determination is made that continued stay will be required and no later than the 13th calendar day following admission, in order to arrange an on-site Level II evaluation.

3. Categorical Progressed Dementia with MR/RC: The individual has mental retardation or a related condition along with a co-occurring diagnosis of progressed dementia, Alzheimer's disease or related disorder. Both of the following must also be present: The diagnosis of dementia, Alzheimer's disease or related disorder must be considered the primary diagnosis and the individual must be considered to be in the advanced stages of this condition and no longer able to meaningfully participate in or benefit from a program of specialized services. Before admission can occur, medical records information which supports that the individual qualifies under this criterion must be provided to the HHS/Contractor along with Forms HHS-OBRA1 and HHS-OBRA1a.

4. Categorical Serious Medical - The individual's medical condition renders him/her unable to benefit from a plan of specialized services and clearly meets criteria for NF care. Applicable conditions include: Coma, Ventilator Dependence, Brain Stem Injury, End-Stage Medical Condition. In order to qualify, medical records information which support that the individual qualifies under this criterion must be provided along with Forms HHS-OBRA1 (see 471-000-223) and HHS-OBRA1a (see 471-000-226) to HHS/contractor before the individual's admission can occur.

5. Exempted Hospital Discharge - Federal regulations also offer an exemption from the Level II PASP process for individuals with mental illness and/or mental retardation/related conditions who meet Exempted Hospital Discharge criteria discussed in 471 NAC 12-004.03.
12-007.02E1 Documentation of Categorical Determinations: The facility shall send Forms HHS-OBRA1, HHS-OBRA1a, and documentation supporting the categorical determination to the HHS/Contractor before admission for an individual with mental illness, mental retardation, or a related condition, or a dual diagnosis may occur under the categorical determination provision:

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

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

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

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

The nursing facility retains a copy of Form HHS-OBRA1 and HHS-OBRA8 in the individual's permanent nursing facility record.
12-007.02G Medicaid Payment: If a Medicaid-eligible client requires a Level II evaluation and is admitted to the nursing facility, Medicaid payment for NF services can begin no earlier than the date of the PASP final determination, following the Level II evaluation.

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

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

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

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

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

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

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

1. A copy of Form DM-5, "Physicians Confidential Report," (see 471-000-221) (completed by the individual's physician) which contains current medical information necessary to determine the kind and amount of medical care needed, or a copy of a current history and physical. Form DM-5 is also used to establish a diagnosis of dementia, Alzheimer's disease, or related disorder according to DSM-III-R criteria and based on a neurological examination.
2. Form DM-5-LTC, "Long Term Care Evaluation" (see 471-000-222), (in its entirety) which contains current nursing, social, and emotional, etc., information necessary to establish the level of care required by the individual (Form DM-5-LTC is completed by an RN or LPN) or Form MC-75 (see 471-000-43) or Form MC-75Q (see 471-000-44). 
   Note: Forms DM-5 and DM-5-LTC must contain the necessary medical information required for the medical and nursing portion of the Level II evaluation (i.e., medical history, neurological evaluation, comprehensive drug history, and response by the individual with mental retardation to specified drugs (i.e., hypnotics, antipsychotics (neuroleptics), mood stabilizers and anti-depressants, anti-anxiety-sedative agents, and anti-Parkinsonian agents).

3. A copy of the Social History which contains current psychosocial information specified in the "Guidelines for Social History" found in 471-000-234. The nursing facility may use its own social summary form as long as it contains the minimum information required for the Level II screening. In facilities with more than 100 beds, the Social History must be completed or countersigned by a certified social worker who is certified by the Department of Health and Human Services Regulation and Licensure.

12-007.03 Other Admission Requirements

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

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

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

1. The client being admitted to the SNF/NF-licensed bed has had a physical examination within 48 hours (two working days) after admission unless an examination was performed within five days before admission;

2. The history and physical can be documented on Form DM-5 (see 471-000-221); Hospital history and physical; or any form used by the physician; and

3. Each medical evaluation at a minimum must include -
   a. Diagnoses;
   b. Summary of present medical findings;
   c. Medical history;
   d. Mental and physical functional capacity; and
   e. Prognosis.
*Note: In accordance with 42 CFR 483.40(f), the Department will allow all but the following required physician tasks in a nursing facility (including tasks that the regulations specify must be performed personally by the physician) to be satisfied when performed by a nurse practitioner or physician's assistant who is not an employee of the facility but who is working in collaboration with a physician according to Nebraska statute and designation of duties:

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

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

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

12-007.03D Admission Forms

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

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

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

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

See 471 NAC 12-009.08 for policy on swing-bed services.
12-007.05 **Advance Directives**: The facility shall comply with the regulations at 471 NAC 2-005 ff.

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

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

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

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

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

1. Initial Assessment: Basic Assessment Tracking (section AA) AB, AC, Full Assessment, Section S;
2. Annual Assessment: AA, Full Assessment, Section S;
3. Significant Change: AA, Full Assessment, Section S;
4. Quarterly Review: AA, Quarterly Review (RUGS II), Section S or AA, Full Assessment, Section S. If full assessment is used, enter "5" in field AA8a and "6" in field AA8b;
5. Short Stay (14 days or less): Discharge Tracking Form, Section S;
6. Discharge: Discharge Tracking Form, Section S;
7. Re-entry (from a Temporary absence): Re-entry tracking form, Section S.
12-007.06D  Definition of Significant Change: A "significant change" is:

1. Deterioration in two or more activities of daily living, communication, and/or cognitive abilities that appear PERMANENT. For example, simultaneous functional and cognitive decline often experienced by residents with chronic degenerative illnesses such as Alzheimer's disease or pronounced functional changes following a stroke;

2. Loss of ability to freely ambulate or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush, or comb. These losses must be PERMANENT and not attributable to identifiable, reversible causes such as drug toxicity from introducing a new medication, or an episode of acute illness such as influenza;

3. Deterioration in behavior, mood, and/or relationships that has not been reversed by current staff interventions;

4. Deterioration in a resident's health status, where this change -
   a. Places the resident's life in danger, e.g., stroke, heart condition, or diagnosis of metastatic cancer;
   b. Is associated with a serious clinical complication, e.g., initial development of a stage III or stage IV pressure ulcer, the initial onset of nonrelied delirium, or recurrent loss of consciousness; or
   c. Is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time, e.g., Alzheimer's disease or diabetes;

5. A serious clinical complication;

6. A new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time;

7. Onset of a significant weight loss (five percent in last 30 days or ten percent in last 180 days); or

8. A marked and sudden improvement in the resident's status, for example, a comatose resident regaining consciousness.

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

1. Is not self-limiting. A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions;

2. Impacts on more than one area of the resident's health status; and

3. Requires interdisciplinary review or revision of the care plan.

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

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

The NF shall document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. The NF shall complete a full comprehensive assessment as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days of determining a significant change has occurred.
**12-007.06D1 Other Changes:** The facility need not assess the resident if declines in a resident's physical, mental, or psychosocial well-being are attributable to –

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

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

**Key Mandated MDS Items for Quarterly Assessment:**

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

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

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

**Section E: Mood and Behavior Patterns**
- Item 1 - Indicators of Depression, Anxiety, Sad Mood  
- Item 2 - Mood Persistence  
- Item 4 - Behavioral Symptoms
Section G: Physical Functioning and Structural Problems
  Item 1 - ADL Self-Performance
  Item 2 - Bathing
  Item 4 - Functional Limitation in Range of Motion
  Items 6a, b, and f - Modes of Transfer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12-007.08A Billing for the Annual Physical Examination: If the annual physical examination is performed solely to meet the Medicaid requirement, the physician shall submit the appropriate professional claim (see Claim Submission Table at 471-000-49) to the Department. If the physical examination is performed for diagnosis and/or treatment of a specific symptom, illness, or injury and the client has Medicare or other third party coverage, the physician shall submit the claim through the usual Medicare or other third party process.
12-007.09 Physician Services: The physician* must see the client whenever necessary, but at least once every 30 days for the first 90 days following admission, and at least once every 60 days thereafter.

At the time of each visit, the physician shall -

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

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

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

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

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

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

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

12-007.13 Freedom of Choice: Each facility shall ensure that any client may exercise his/her freedom of choice in obtaining NMAP-covered services from any provider qualified to perform the services (see 471 NAC 1-004.02). Clients participating in Medicaid managed care must comply with the conditions of their managed care plan.
12-007.14 Room and Bed Assignments: Facility staff shall maintain a permanent record of the client's room and bed assignments. This record must show the dates and reasons for all changes and be maintained in the nurses' notes in the health chart/medical record.

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

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

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

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

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

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

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

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

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

1. Obtain physician's written order for transfer;
2. Obtain written consent from the client, his/her family, and/or guardian;
3. Notify the local office that handles the client's case in writing, stating -
   a. The reason for transfer;
   b. The name of facility to which the client is being transferred; and
   c. The date of transfer;
4. Transfer the following to the receiving facility:
   a. Necessary medical/social/PASP information (including the ID screen and evaluation packet);
   b. Any non-standard wheelchair and wheelchair accessories/options/components, including power operated vehicles;
   c. Any Augmentative Communication Devices with Related Equipment and Software;
d. Supports (e.g. trusses and compression stockings with related components); and
e. Custom fitted and/or custom fabricated items.
Note: These above items specifically purchased for and used by the client shall be transferred with the client.
5. Document transfer information in the client's record and discharge summary.

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

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

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

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

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

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

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

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

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

1. Provide any information about the discharged client that will ensure the optimal continuity of care to those persons responsible for the individual's post-discharge care.

2. Include current information on diagnosis, prior treatment, rehabilitation potential, physician advice concerning immediate care, and pertinent social information.

3. Discharge the following items specifically purchased for and used by the client with the client:

   a. Any non-standard wheelchair and wheelchair accessories, options, and components, including power operated vehicles;
   b. Any augmentative communication devices with related equipment and software;
   c. Supports (e.g. trusses and compression stockings with related components); and
   d. Custom fitted and/or custom fabricated items.
12-008 Appeals of Discharges, Transfers, and PASP Determinations: A resident of a skilled nursing facility (SNF) or a nursing facility (NF) who receives a notice from the SNF or NF of the intent to discharge or transfer the resident may appeal to the Department of Health and Human Services Finance and Support for a hearing on this notice. The appeal and hearing must be conducted under 465 NAC 2-001.02 and 6-000 ff.

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

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

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

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

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

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

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

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

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

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

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

When a PASP is not performed before admission, Medicaid payment for nursing facility services is available only for services provided after the PASP is completed.
12-009.05 Items Included in Per Diem Rates: The following items are included in the per diem rate:

1. **Routine Services**: Routine nursing facility services include regular room, dietary, and nursing services; social services and activity program as required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:
   
a. All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; hand-feeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
   b. Maintenance Therapy: facility staff shall aid the resident as necessary, under the resident's therapy program, with programs intended to maintain the function(s) being restored including but not limited to augmentative communication devices with related equipment and software;
   c. Items which are furnished routinely and relatively uniformly to all patients, such as patient gowns, linens, water pitchers, basins, bedpans, etc.;
   d. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, band-aids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, 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, parenteral or enteral feeding;
   g. Laundry services, including personal clothing; and
   h. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.

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

4. **Contracted Services**: The nursing facility shall contract for services not readily available in the facility -
   a. If the service is provided by an independent licensed provider who is enrolled in Medicaid (i.e., physical therapist or physician) the provider shall submit a separate claim (Form HCFA-1500) for each person served; and
   b. If the service is provided by a certified provider of medical care (i.e., QMRP assessment or respiratory therapist) the nursing facility is responsible for payment to the provider. This expense is an allowable cost.

5. **Single Room Accommodations**: Medicaid residents should be afforded equal opportunity to remain in or utilize single-room accommodations. Any facility that prohibits or requires an additional charge for Medicaid utilization of single-room accommodations must make an appropriate adjustment on its cost report to remove the additional cost of single-room accommodations. To make the adjustment, 50% of the facility’s fixed cost per diem multiplied by the number of supplemented Medicaid days of care must be subtracted from the facility’s reported cost. The facility must not make an additional charge for a therapeutically required single room nor is the facility required to make a cost report adjustment for this type of room. Each facility must have a written policy on single-room accommodations for all payers.

12-009.06 Items Not Included in Per Diem Rates

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

1. Any non-standard wheelchairs and wheelchair accessories, options, and components, including power-operated vehicles needed for the client's permanent and full time use (see 471 NAC 7). Standard wheelchairs are considered necessary equipment in an NF to provide care and part of the per diem.
2. Air fluidized bed units and low air loss bed units (see 471 NAC 7); and
3. Negative Pressure Wound Therapy, (See 471 NAC 7).
12-009.06B Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16);
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses (see 471 NAC 24), hearing aids (see 471 NAC 8), etc.;
3. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7;
4. Prostheses (e.g. breast, eye, lower and upper limb) as defined in 471 NAC 7; and
5. Ambulance services (See 471 NAC 4).
12-009.06C  May Be Charged to Resident's Funds: Items that may be charged to residents' funds and are not considered as part of the facility's Medicaid per diem are -

1. Telephone;
2. Television/radio for personal use (except cable service);
3. Personal comfort items, including smoking materials, notions, and novelties, and confections;
4. Cosmetic and grooming items and services that are specifically requested by the client and are in excess of the basic grooming items provided by the facility;
5. Personal clothing;
6. Personal reading matter;
7. Gifts purchased on behalf of the client;
8. Flowers and plants;
9. Social events and entertainment offered outside the scope of the activities program required by certification;
10. Non-covered special care services such as privately hired nurses or aides specifically requested by the client and/or family;
11. Specially prepared or alternative food requested instead of the food generally prepared by the facility (as required by certification); or
12. Single room, except when therapeutically required (for example, isolation for infection control).
12-009.06D Other: The facility must meet the following requirements:

1. The facility must not charge a client (or his/her representative) for any item or service not requested by the resident.
2. The facility must not require a resident (or his/her representative) to request any item or service as a condition of admission or continued stay.
3. The facility must inform the client (or his/her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

12-009.07 Payment for Bed-holding: The Department makes payments to reserve a bed in a NF during a client's absence due to hospitalization for an acute condition and for therapeutically-indicated home visits. Therapeutically-indicated home visits are overnight visits with relatives and friends or visits to participate in therapeutic or rehabilitative programs. Payment for bed-holding is subject to the following conditions:

1. A "held" bed must be vacant and counted in the census. The census must not exceed licensed capacity;
2. Hospital bed-holding is limited to reimbursement for 15 days per hospitalization. Hospital bed-holding does not apply if the transfer is to the following: NF, hospital NF, swing-bed, a Medicare-covered SNF stay, or to hospitalization following a Medicare-covered (SNF) stay;
3. Therapeutic leave bed-holding is limited to reimbursement for 18 days per calendar year. Bed-holding days are prorated when a client is a resident for a partial year;
4. A transfer from one facility to another does not begin a new 18-day period;
5. The client's comprehensive care plan must provide for therapeutic leave;
6. Facility staff must work with the client, the client's family, and/or guardian to plan the use of the allowed 18 days of therapeutic leave for the calendar year; and
7. Qualifying hospital and therapeutic leave days will be reimbursed at the facility's bed-hold rate (Level of Care 105), as identified in 471 NAC 12-011.08F.

12-009.07A Special Limits: When the limitation for therapeutic leave interferes with an approved therapeutic or rehabilitation program, the facility may submit a request for special limits of up to an additional six days per calendar year to the Medicaid Division. Requests for special limits must include:

1. The number of leave days requested;
2. The need for additional therapeutic bed-holding days;
3. The physician's orders;
4. The comprehensive plan of care; and
5. The discharge potential.

It is mandatory that the NF report all bed-holding days on the monthly Form MC-4, "Long Term Care Facility Turnaround Billing Document" (see 471-000-82), UB04 claim form (see 471-000-71), or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837).
12-009.07B Use of Form MC-10: When a client, who was receiving Medicaid-covered NF services, returns from a hospital stay and is admitted for Medicare-covered services, a Form MC-10 is used to inactivate the authorization for Medicaid payment, effective the date on which the client is admitted to the Medicare-covered bed. The local office shall complete and submit another Form MC-10 to re-activate authorization for Medicaid payment when Medicare services are denied.

If the client is discharged from the hospital to swing bed care or to another nursing facility, the local office shall complete and submit Form MC-10 to deactivate Medicaid prior authorization. Note: The Department encourages the facility to communicate frequently with the hospital discharge planner to keep aware of the client's medical status.

12-009.07C Reporting Bedholding Days: Facilities shall report bedholding days on Printout MC-4, "Long Term Care Facility Turnaround Billing Document," (see 471-000-82). The appropriate bedholding days are reported in the "leave days therapeutic" or "leave days hospital" columns. If billing electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837), the appropriate bedholding days are reported in accordance with billing instructions (see 471-000-82). If billing on the UB04 claim form, the appropriate bedholding days are reported in accordance with the billing instructions (see 471-000-71). The nursing home days are adjusted to the actual number of days the client was present in the facility at 12:00 midnight.

12-009.08 Swing Beds: Medicaid covers only skilled nursing care (client requires 24-hour professional nursing care) for swing beds. Also see 471 NAC 10-014 ff. Swing bed services are services that meet the requirements of 42 CFR 483, Subpart B. Nursing or rehabilitation services which must be provided by or under the direct supervision of professional or technical personnel and require skilled knowledge, judgment, observation, and assessment may include, but are not limited to, the following:

1. Orally administered medications which require changes in dosage due to undesirable side effects or reactions, e.g., anticoagulants, Quinidine, etc. These must be administered to the patient by licensed nurses;
2. Frequent intravenous or intramuscular injections, except self-administered types such as insulin for a well-regulated diabetic;
3. Narcotics and controlled substances used on a p.r.n. (as circumstances may require) basis. Care relative to these substances must be documented in nurses' notes and physicians' orders with progress notes which contain observations made of the physical findings, new developments in the disease cause, how the prescribed treatment was implemented, and the resultant effects of the treatment;
4. Supplementation of physician care when -
   a. Uncontrolled or unstable medical conditions exist; and/or
   b. Observations of and instructions to the patient are needed relative to critical complications and evaluation of progress;
5. Initial phases of a medical regimen involving the administration of medical gases as directed by physicians' orders;
6. Physician-ordered restorative procedures which, because of the type of procedure or the patient's condition, must be performed by or under the direct supervision of the appropriately qualified therapist as defined in 42 CFR 483.45 (Note: Maintenance therapy is not skilled nursing care);
7. Colostomy or ileostomy care during the post-operative period until routine care is established.
8. Frequent catheterization or indwelling catheter care: urinary, bile ducts, chest, etc., or in combination with other skilled services;
9. Application of aseptic dressings and treatments (i.e., wound, tracheostomy care);
10. Nasopharyngeal aspiration and throat suctioning;
11. Levine tube and gastrostomy feedings; and
12. Decubitus ulcers - Stage III or IV.

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

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

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

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

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

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

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

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

Laboratory, radiology, respiratory therapy, physical therapy, occupational therapy, and speech pathology and audiology services must be billed on Form CMS-1450 or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837) as outpatient services. These payment must be reported on the Medicare cost report as outpatient revenues.
12-09.08F Therapy: Certain services, defined as "waiver claims" are an exception to the requirement of 471 NAC 3-004.03 regarding third party liability. Nursing facility services are included in the definition of "waiver claims." Providers may submit these claims to Medicaid before filing for third party liability (TPL); NMAP pays the nursing facility claims and COB staff initiate recovery activities for any third party resource. This does not prohibit the provider from billing the third party resource (TPR) before billing Medicaid.

12-010 (Reserved)
12-011 Rates for Nursing Facility Services

12-011.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost means those facility costs which are included in the computation of the facility's per diem. The facility's reported costs may be reduced because they are not allowable under Medicaid or Medicare regulation, or because they are limited under 471 NAC 12-011.06.

Assisted Living Rates means standard rates, single occupancy, rural or urban, per day equivalent, paid under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Department means the Nebraska Department of Health and Human Services.

Division means the Division of Medicaid and Long-Term Care.

IHS Nursing Facility Provider means an Indian Health Services Nursing Facility or a Tribal Nursing Facility designated as an IHS provider and funded by the Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

Level of Care means the classification of each resident based on his/her acuity level.

Median means a value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

Nursing Facility means an institution (or a distinct part of an institution) which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

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


Rate Determination means per diem rates calculated under provisions of 471 NAC 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 101, 102, 103 and 104, adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).
Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 101, 102, 103, 104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5) adjusted to include the Nursing Facility Quality Assurance Assessment component (see 471 NAC 12-011.08D).

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


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

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

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

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

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

Except for IHS nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 471 NAC 12-011.08B) will not file a cost report. The rate paid will be based on the average base rate components, effective July 1 of the rate period, of all other providers in the same care classification, following the initial desk audits.
12-011.04 Allowable Costs: The following items are allowable costs under Medicaid.

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

1. Meet the definition and requirements for a Nursing Facility of Title XIX of the Social Security Act, Section 1919;
2. Comply with the standards prescribed by the Secretary of the federal Health and Human Services (HHS) for nursing facilities in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health, the state agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.
12-011.04B Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:

1. General nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; hand-feeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
2. Maintenance Therapy: facility staff must aid the client as necessary, under the client’s therapy program, with programs intended to maintain the function(s) being restored, including but not limited to augmentative communication devices with related equipment and software;
3. Items which are furnished routinely and relatively uniformly to all clients, such as patient gowns, water pitchers, basins, bedpans, etc.;
4. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, band-aids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.);
5. Items which are used by individual clients which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc. not listed in 12-009.05 and 12-009.06;
6. Nutritional supplements and supplies used for oral, parenteral or enteral feeding;
7. Laundry services, including personal clothing;
8. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service;
9. Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance;
10. Injections and supplies: including syringes and needles, but excluding the cost of the drug(s) not listed in 12-009.05 and 12-009.06;
12-011.04C Ancillary Services: Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as "routine services." The facility must contract for ancillary services not readily available in the facility.

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

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

Respiratory therapy is an allowable cost.

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

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and diluents (see 471 NAC 16). Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses (see 471 NAC 24), hearing aids (see 471 NAC 8), etc.;
3. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7;
4. Prostheses (breast, eye, lower and upper limb) as defined in 471 NAC 7;
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4.
   a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, Medicaid will not make payment for ambulance service.
   b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the Nursing Facility).
12-011.04E Payments to Nursing Facility Provider SEPARATE from Per Diem Rates:

Items for which payment may be made to Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item outlined in the appropriate Medicaid provider chapter.

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

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

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

14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts; and

15. Revisit fees.

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

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

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

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

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

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

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

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

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.
12-011.06D  Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

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

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

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

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the federal Department of Health and Human Services (HHS), or their designated representatives.
12-011.06F Home Office Costs - Chain Operations: A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.

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

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

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

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

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

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

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.
12-011.06J Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 12-011, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

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

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

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

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

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

This computation is made by dividing the total allowable Direct Nursing and Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing and Support Services components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.
12-011.06M Direct Nursing Costs: Direct nursing costs include cost report lines 94 through 103. The following descriptions cover some of these costs:

1. Salaries of the Director of Nursing and other licensed health professionals (RNs & LPNs) who are practicing within the scope of their license;

2. Salaries of other licensed or certified individuals providing routine nursing or routine nursing-related services to residents; and unlicensed, assistive personnel providing nursing-related support for direct nursing care to residents. Nursing-related support includes, but is not limited to: bathing, dressing, transfer, dining assistance, bed mobility, walking, range of motion, bed making, filling water pitchers, personal hygiene, administration of medications and other activities of daily living; or training/instruction of residents in these services;

3. Salaries directly related to:
   a. Nursing staff scheduling;
   b. Preparation of resident assessments, development of care plans, and other required documentation;
   c. Instruction of and attendance at nursing inservice training;
   d. Medical records, including record transcription, file thinning, setup of initial files, and other medical record services; and
   e. Quality assurance services;

4. The documented nursing portion of multi-purpose and/or universal workers’ salaries:
   a. A multi-purpose employee has nursing and non-nursing job duties. For example, medical records (Nursing) and payroll (Administration).
   b. Universal workers are employees who perform multiple tasks for residents, usually in a distinct unit, pod, or neighborhood. The tasks performed by the universal workers have traditionally been divided between employees of separate departments. Services provided by universal workers may include two or more of the following functions:
      (1) Nursing;
      (2) Activities;
      (3) Laundry;
      (4) Housekeeping; and
      (5) Dietary;
   c. Multi-purpose and/or universal workers who perform services in more than one functional area must identify their time using one of the following approved methods:
      (1) Maintenance of daily continuous timesheets – The daily timesheet must document, for each day, the person’s start time, stop time, total hours worked, and the actual time worked in each functional area;
      (2) Maintenance of time studies as defined in Medicare HIM-15 (section 2313.2E);
      (3) Other methods as pre-approved by the Department;

5. Payroll taxes and employee benefits related to the salaries outlined above. Employee benefits DO NOT include help wanted advertising, pre-employment physicals, background checks, etc;

6. Consulting Registered Nurse;
7. Salary, payroll taxes and employee benefits of home office nursing personnel while performing facility-specific direct care nursing services, if the costs are allocated according to Medicare HIM-15, Section 2150.3B. Related overhead costs, including, but not limited to, travel time, lodging, meals, etc., cannot be reported as Direct Nursing costs. Report overhead costs in the Administration cost category; and

8. Purchased Services – Direct Care (pool nurse labor). Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply.

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

1. Costs of routine maintenance services performed by an outside vendor rather than by the provider’s maintenance staff. Examples include lawn care, alarm maintenance/monitoring, pest control and snow removal;

2. Costs of incidental supplies and materials used by maintenance personnel and/or maintenance contractors in maintaining or repairing the building, grounds and equipment (excluding business equipment). Examples include paintbrushes, tools, hardware items (screws, nails, etc.), fertilizer, lumber for small projects and electrical & plumbing supplies. Aviary and other pet supply costs are to be reported in the Activities cost category;

3. Repairs and maintenance applicable to the building, grounds, equipment (excluding business equipment) and vehicles. Report maintenance and repair expenses applicable to business equipment (e.g. computers, copiers, fax machines, telephones, etc.) as an Administration expense.

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

1. Example 1: The provider has a 5-year copier lease. Monthly lease payments are based on the number of copies made. These costs must be reported in the Administration cost category.

2. Example 2: The provider has a maintenance agreement for a dishwasher. A condition of the agreement requires a minimum monthly purchase of dishwasher supplies. These costs must be reported in the Dietary cost category.

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

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

12-011.07 (Reserved)
12-011.08 Rate Determination: The Department determines rates for facilities under the following cost-based prospective methodology.

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

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

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

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

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

Each facility's prospective rates consist of four components:

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

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

Median: For each Care Classification, the median for the Direct Nursing Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding waived, and/or facilities with partial or initial/final full year cost reports. For each Care Classification, the median for the Support Services Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding hospital based, waived, and/or facilities with partial or initial/final full year cost reports.
The Department will reduce the Direct Nursing Component median by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities’ lowered nursing care costs.

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

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

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

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

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

12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, or a maximum per diem of $27.00 excluding personal property and real estate taxes.
12-011.08D4 Nursing Facility Quality Assessment Component: The Nursing Facility Quality Assessment component shall not be subject to any cost limitation or revenue offset.

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

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

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

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

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

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

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

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

The DME rate add-on does not apply to Levels of Care 101-105.
Retroactive rate settlements computed according to 471 NAC 12-011.08H1 will not include a DME rate add-on as actual DME costs will be included in the reported Support Services – Other Nursing costs. To account for these increased Support Services costs on retroactive rate settlements only:

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

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility’s rate computed for its Fixed Cost Component. An exception may only be requested if the facility’s total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility’s request must include:

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

12-011.08F Rate Payment for Levels of Care 101, 102, 103, 104 and 105: Rates as determined for Levels of Care 101, 102, 103 and 104 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. Level of Care 105 is used for payment of qualifying bed-hold days. The payment rate for Levels of Care 101, 102, 103, 104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5), adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at a rate established by that state’s Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.
12-011.08H Rates for New Providers:

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

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

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

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

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

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

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

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

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

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

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

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

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

When “new provider” status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.
Medicaid rates for new IHS nursing facility providers are determined as follows:

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

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

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

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

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

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

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

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

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

When “new provider” status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.
12-011.08K Special Funding Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transaction to increase reimbursement. The transaction is subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles). City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility.

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

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

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

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

3. The Special Funding amount is computed after desk audit and determination of allowable costs for the report period. The amount is calculated by adding the following two figures:
a. The allowable Federal Medical Assistance Percentage for IHS-eligible Medicaid residents multiplied by the difference between the allowable costs for all IHS-eligible Medicaid residents and the total amount paid for all IHS-eligible Medicaid residents, if greater than zero: and

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

12-011.08M (Reserved)
12-011.09 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare’s Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

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

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

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

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

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

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

12-011.09B2 Acquisitions: If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and an allowable cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has an allowable cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.
12-011.09B3 Acquisitions Under $100: Acquisitions after July 1, 2005 with a per unit cost of less than $100 cannot be depreciated. Costs of these items are included in the applicable operating cost category on the Cost Report in the current period. Examples:

<table>
<thead>
<tr>
<th>Item</th>
<th>Per Item Cost</th>
<th>Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toaster</td>
<td>$38</td>
<td>Dietary Supplies</td>
</tr>
<tr>
<td>30 Wastebaskets</td>
<td>$22 ($660 total)</td>
<td>Housekeeping Supplies</td>
</tr>
<tr>
<td>Calculator (bookkeeper)</td>
<td>$95</td>
<td>Administration Supplies</td>
</tr>
<tr>
<td>Pill Crusher</td>
<td>$62</td>
<td>Nursing Supplies</td>
</tr>
<tr>
<td>Wrench Set</td>
<td>$77</td>
<td>Plant Related Supplies</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

**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.

<table>
<thead>
<tr>
<th>Item</th>
<th>Per Item Cost</th>
<th>Cost Report Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Computers</td>
<td>$1,750 (total = $8,750)</td>
<td>Capitalize &amp; Depreciate</td>
</tr>
<tr>
<td>Boiler</td>
<td>$12,500</td>
<td>Capitalize &amp; Depreciate</td>
</tr>
<tr>
<td>TV for Day Room</td>
<td>$1,300</td>
<td>Plant Related</td>
</tr>
<tr>
<td>Lawn Mower</td>
<td>$2,500</td>
<td>Capitalize &amp; Depreciate</td>
</tr>
<tr>
<td>Range/Oven</td>
<td>$4,900</td>
<td>Plant Related</td>
</tr>
<tr>
<td>Resident Room Carpet</td>
<td>$800</td>
<td>Capitalize &amp; Depreciate</td>
</tr>
<tr>
<td>10 Resident Beds</td>
<td>$700 (total = $7,000)</td>
<td>Capitalize &amp; Depreciate – as aggregate cost of $7,000 is more than $1,500</td>
</tr>
<tr>
<td>3 Cubicle Walls &amp; Desktop</td>
<td>$300 (total = $900)</td>
<td>Capitalize &amp; Depreciate – as cost of integrated system is greater than $1,500</td>
</tr>
<tr>
<td>Desktop</td>
<td>$700</td>
<td></td>
</tr>
<tr>
<td>For an Office Cubicle</td>
<td>(total = $1,600)</td>
<td></td>
</tr>
</tbody>
</table>
12-011.09C Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

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

12-011.09D (Reserved)

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

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

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

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.

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

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

**Example A**

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

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

**Example B**

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

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

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

12-011.09G Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.
12-011.10 Reporting Requirements and Record Retention: Providers with greater than 1,000 Medicaid inpatient days for a full Report Period must submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation will prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes.

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

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

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

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

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

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

Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department will retain all cost reports for at least five years after receipt from the provider.
Facilities which provide any services other than certified nursing facility services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. A Medicare certified facility must not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

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

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

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

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

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.
The Department may not initiate an audit:

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

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

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

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

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

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

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

After the Director of the Division of Medicaid and Long-Term Care issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.
12-011.14A  MDS 2.0 Reconsideration Process (effective only through September 30, 2010): In place of or in advance of requesting an administrative appeal, a facility may request a rate payment reconsideration with the Department or its designee for a specific Level of Care 101, 102, 103 or 104 resident. The facility must submit information on the client’s need for professional medical care, supervision or other needs that justify a rate payment at Level 191, 192, 193 or 194. Note: The reconsideration process neither limits nor promotes the facility’s responsibility to make MDS changes on a quarterly basis or whenever a significant change has occurred, as federally defined.

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

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

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

The following conditions do not constitute valid reasons for reconsideration:

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

12-011.14A1  Effective Date of Reconsideration: A facility may request a rate reconsideration review for MDS 2.0 assessments by December 31, 2010. If granted, the adjusted rate will be effective the first day of the month for which the resident’s need for medical supervision or intervention is documented, retroactive for a period not to exceed three calendar months before the first day of the month in which the reconsideration request and supporting documentation is received by the Department or its designee.
12-011.15 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

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

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

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

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

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

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

12-012.01 Who Must File: Any long term care provider located in Nebraska that has a long term care provider agreement with the Department must report its costs on Form FA-66, "Long Term Care Cost Report."
12-012.02 When to File: The provider must file the cost report within 90 days after:

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

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

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

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

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

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

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

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

Complete all the items in the GENERAL DATA schedule.

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

Complete SCHEDULE A, PART 1.

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

Complete SCHEDULE A, PART 2.

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

Complete: SCHEDULE B, PART 1, COLUMN B
SCHEDULE B, PART 2, COLUMN B
SCHEDULE B, PART 3, COLUMN B
SCHEDULE B, PART 4, COLUMN B
SCHEDULE C
Review the General Cost category on Schedule B, Part 3, and determine if cost adjustments are needed to reclassify payroll taxes or employee benefits.

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

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

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

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

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

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

Obtain job descriptions for all owners, directors, or other related parties who received compensation.

Complete SCHEDULE B-3 if any of the payroll includes payments to owners, directors, or related parties.

Review the revenue and cost and determine if any other operating or ancillary costs are included that cannot be considered for reimbursement. Determine how to make the necessary changes for reimbursement -

- offset of the related revenue,
- direct cost adjustment, or
- allocation of the costs.

Record revenue offsets on: SCHEDULE B, PART 1, Columns C & D
SCHEDULE B, PART 2, Columns C & D

Record direct cost adjustments on SCHEDULE B-4. Use the defined lines when possible. Use the blank lines for other adjustments.

Note any items to be allocated. Allocations are completed later in the report process.

Obtain copies of the signed leases if amounts are reported for fixed long term leases.

Review the leases and determine if any adjustments are necessary for leases not related to the long term care portion of the facility.

Record the adjustments on SCHEDULE B-4. Use the blank lines provided for other adjustments.
Complete SCHEDULE F, PART 1, lines 1 through 5 for all remaining fixed long term lease costs.

Complete SCHEDULE F, PART 2 for each lease that may involve ownership cost adjustments.

Complete SCHEDULE F, PART 1, lines 6 through 18. Transfer total lease adjustment data to the other schedules as indicated on the form.

Obtain an itemized depreciation schedule if depreciation is included in the reported cost.

Complete SCHEDULE D, PART 1, Columns B and C.

Review the assets listed on the detailed depreciation schedule and determine if any adjustments are necessary to remove assets not used in the long term care program or to adjust the cost bases for Medicaid reimbursement.

Report the fixed asset cost adjustments on SCHEDULE D-1.

Summarize the Schedule D-1 adjustments on SCHEDULE D, PART 1, Column D.

Complete the remainder of SCHEDULE D, PART 1. Transfer the adjustment from Line 30 to SCHEDULE B-4 as indicated on the form.

Complete SCHEDULE D, PART 2 if any assets have been added to the long term care value during the report period.

Complete SCHEDULE D, PART 3 if any assets have been removed from the long term care value during the report period.

Obtain copies of signed loan agreements if interest is included in the reported cost.

Complete SCHEDULE E, PART 1, Columns A, B, C, D, E, and F.

Review the loan agreements and determine if any adjustments are needed to remove loans not related to long term care or to change the loans to amounts allowable for Medicaid reimbursement.

Report the loan adjustments on SCHEDULE E-1.

Summarize the Schedule E-1 adjustments on SCHEDULE E, PART 1, Column G.

Complete the remainder of SCHEDULE E, PART 1. Transfer the adjustments from Line 11 to SCHEDULE B-4 as indicated on the form.

Complete SCHEDULE E, PART 2. Transfer the adjustment to Schedule B-4 as indicated on the form.
Summarize the revenue offsets (Schedule B, Parts 1 and 2) on SCHEDULE B, PART 3, Column C.

Summarize the cost adjustments (Schedule B-1, B-2, B-3, and B-4) on SCHEDULE B, PART 3, Column D.

Complete SCHEDULE B, PART 3, Column E.

Review the costs for allocation and determine the appropriate allocation basis for each line. Obtain the statistical records maintained by the provider.

Complete SCHEDULE B-5. Report only the statistics needed to complete the allocations.

Complete SCHEDULE B, PART 3, Column F. EACH LINE WITH AN AMOUNT TO ALLOCATE MUST HAVE A SCHEDULE B-5 ALLOCATION BASIS NUMBER RECORDED IN COLUMN F.

Complete SCHEDULE B, PART 3, Columns G and H.

Review all the information contained in the report. Make sure that all schedules are completed and that the information is correct.

The preparer completes the "Preparer Acknowledgement" at the end of the report packet and attaches the preparation report.

The owner, officer, or administrator authorized to act on behalf of the provider must review the report and complete the certification.

ALL REPORTS MUST BE SIGNED BY THE PROVIDER MANAGEMENT.

12-012.07 General Data

12-012.07A Description: The General Data Section, located on page 1 of the report form, is used to report information about the provider, the cost report, and the accounting records.

12-012.07B Definitions: Definitions of the information requested on of the General Data section follow.

1. Provider Number - Report the Medicaid long term care provider number assigned to the nursing facility. If the number changed during the report period, report the provider number in effect at the end of the period. Include one character in each field of the entry area. All fields, including the two digit suffix, must be completed.

2. Mailing Address - Report the commonly used facility name and the address used to receive mail for the facility.

3. Location Address - Report the street address if it is not used in the mailing address.
4. Telephone Number - Report the telephone number for the facility. If the facility has more than one number, include the number of the administrative offices.

5. Location in an Urban Area - Mark the appropriate box:
   
   **YES**, if the facility is located in Douglas, Lancaster, Sarpy, or Washington County.
   
   **NO**, if the facility is located in any other county.

6. Licensed as - Mark the box that applies to the facility:

   **NURSING FACILITY**, if the facility is licensed by HHS R & L as a Nursing Facility.

   **HOSPITAL**, if the facility is licensed by HHS R & L as a hospital.

7. Long Term Care Certified for - Mark the box or boxes that apply at any time during the report period:

   **NF**, if the facility had any or all beds certified for nursing facility only.

   Waivered - Mark the box that applies to the facility:

   **YES**, if the facility was waivered at any time during the report period.

   **NO**, if the facility was not waivered at any time during the report period.

   **ICF/MR**, if the facility had any or all beds certified for intermediate care of the mentally retarded services.

8. Type of Control - Mark the box that describes the provider's organizational structure. The choices are self-explanatory.

9. Medicare Participation - Mark the boxes that apply:

   **YES**, if the facility participates in the Medicare Part A and/or Part B program.

   **NO**, if the facility does not participate in the Medicare program.

   If yes was marked, report the provider number assigned for participation in the Medicare program and the fiscal intermediary for the Medicare program.
10. Report Period - Report the beginning and the ending dates of the period covered by the cost report. Include a character in each field of the entry area. Use leading zeros when needed.


11. Report Type - Mark the boxes that apply:

REGULAR REPORT PERIOD, if the report is for a full report period of July through the following June.

CLOSING, if the report period includes the date NF services or participation in the NMAP discontinued at the facility.

OPENING, if the report period includes the date NF services or participation in the NMAP started at the facility.

12. Facility Regular Fiscal Year - Report the annual period used in the provider's normal course of business. It may be different than the report period used for the Nebraska Long Term Care Cost Report.

13. Central Office for Chain Providers - If the provider is an entity of a chain of providers, report the central office name, address, and telephone number. If applicable, also include the name of the person in the central office responsible for or most familiar with coordination with the Medicaid programs.

14. Accounting Records Maintained at - Report the name, address, and telephone number of the office where the major portion of the provider's accounting records are located. If this is the same as another address reported in the General Data section, a reference to that item number may be reported rather than repeating the information.

15. Accounting Firm and Representing Accountant - Report the name, address, and telephone number of any accountant or accounting firm used by the provider for accounting, auditing, report preparation or other activity related to the financial records of the provider. Also report the name of the individual at the firm most familiar with the work done for the provider.
16. Does the facility have an annual certified audit? Mark the box that applies:

**YES**, if the provider's financial records for any portion of the report period were included in a certified audit conducted by a licensed certified public accountant.

**NO**, if the provider's financial records have not been audited by a licensed certified public accountant.

Complete all boxes in the General Data Section. If a particular item does not apply to the provider, mark that item as not applicable (N/A). If more space is needed for an item write “See Attachment ##” and report the information on an attached sheet.

**12-012.08 Schedule A, Occupancy Data, Description**: Schedule A is a two-part schedule located on pages 1 and 2 of the report form.

**12-012.08A Schedule A, Part 1, Required Occupancy, Description**: Part 1, located on page 1 of the report form, is used to report the provider's long term care licensure and certification information for all days during the report period. It includes space to report any changes that occurred during the period. This part is also used to determine bed days available and report the bed days subject to the occupancy limitations used by the Department.

**12-012.08B Definitions**: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule A.

**A** Period Covered - Report the period that each license or certification level was in effect. The first date entered is the first day of the report period. The last date entered is the last day of the report period. Report each change as it was approved by HHS R & L and the Department. Display entries in this column as month, day, and year (example: July 1, 2004 is displayed 7/1/04).

**B** Days Covered - For each "period covered" entered in Column A, compute the number of days that the licensure/certification was in effect. The total of all lines will be 365 for a full report period (366 for leap years).

**C** Number of Licensed Beds Certified for NF Services - Report the long term care beds licensed and certified for nursing facility services.

**D** NF Bed Days Available - Multiply the number of days reported in Column B by the NF certified beds in Column C and record the result in this column.
Add the bed days available in Columns D and record the totals on Line 2.

On Line 3 report the number of bed days available meeting the conditions for the 50 percent occupancy limitation. Report the remaining bed days available on Line 4.

DO NOT WRITE IN THE BLANK SPACES AT THE END OF THE SCHEDULE.

If additional lines are needed, mark “See Attachment #”", report the information on the attached sheet, and transfer the totals of Columns B and D from the attachment to the form.

12-012.08C Schedule A, Part 2, Census Data, Description: Part 2, located on page 2 of the report form, is used to report the patient services provided. Lines 1 through 3 apply to NF services provided and line 4 applies to other services provided at the facility.

12-012.08D Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule A.

A Month - Sets the order for reporting monthly information. Use only the months covered by the cost report.

In Columns B through J, the Column titles used in the definition will refer to "Long Term Care Services". Report the requested census data for NF services on Line 1 through 3.

B Long Term Care Services; Private; In-House - Report the number of days that a private resident actually occupied a long term care bed at midnight. A private resident is responsible for payment of the facility established rate for services provided.

C Long Term Care Services; Private; Hold - Report the number of days that a bed was actually held for a private resident, subject to limitations at 471 NAC 12-011.06B.

D Long Term Care Services; Private; Total - Add Column B and Column C and record the total in this column.

E Long Term Care Services; Nebraska Medicaid; In-House - Report the number of days that a Nebraska Medicaid resident actually occupied a long term care bed at midnight. A Nebraska Medicaid resident is a resident whose service has been paid by the Department.

F Long Term Care Services; Nebraska Medicaid; Hold - Report the number of days that a bed was actually held for a Nebraska Medicaid resident, subject to limitations at 471 NAC 12-011.06B.

G Long Term Care Services; Nebraska Medicaid; Total - Add Column E and Column F and record in the total in this column.
H  Long Term Care Services; Other NF; In-House - Report the number of days that other long term care residents actually occupied a long term care bed at midnight. Other long term care residents include residents for whom services are paid by another State's Medicaid program, Medicare, Veterans, or other programs.

I  Long Term Care Services; Other NF; Hold - Report the number of days that a bed was actually held for other long term care residents, subject to limitations at 471 NAC 12-011.06B.

J  Long Term Care Services; Other NF; Total - Add Column H and Column I and record the total in this column.

The titles used for definitions of Columns K through M refer to "Other Than Long Term Care". Report residential or other services (not NF) provided in the long term care beds.

K  Other Than Long Term Care; In-House - Report the number of days that other residents actually occupied a long term care bed at midnight.

L  Other Than Long Term Care; Hold - Report the number of days that a long term care bed was actually held for other residents.

M  Other Than Long Term Care; Total - Add Column K and Column L and record the total in this column.

Add the census days reported on each column of Item 1 and record the totals on Line 2.

Add the days reported on Line 2, Columns D, G, and J and record the "Total NF Days" on Line 3. Copy the total from Line 2, Column M to "Total Other Days" on Line 3.

Report census days for services provided in areas not licensed for long term care, including all hold days, on line 4.

An inpatient day is counted at midnight. Midnight is the end of a day; therefore, count the day of admission and not the day of dismissal. Report one day for an individual admitted and deceased on the same day.

All hold days are reported consistent with the limitations imposed for payment by the Nebraska Medicaid program. Therefore, all resident hold days are limited to 15 per hospital stay and 18 per year for therapeutic home visits, REGARDLESS OF THE NUMBER OF DAYS PAID. (36 therapeutic home visits for ICF/MR residents.)
12-012.09 Schedule B, Revenue and Costs, Description: Schedule B is a four-part schedule located on pages 3 through 15 of the report form.

12-012.09A Schedule B, Part 1, Patient Revenues, Description: Patient Revenues includes four sections: Medicaid LTC Patient Revenues and the Private LTC Patient Revenues sections, located on page 3, and Other Payor LTC Patient Revenues and Other Than LTC Patient Revenues sections, located on page 4. The first three sections are used to report revenue from long term care services. The fourth section is used to report patient revenues not related to the long term care program.

This part of the schedule is also used to report any amounts included in the patient revenues which should be used to offset the costs.

12-012.09B Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category/Account Description - This column provides the description of the information requested. Most account descriptions are on the form. Some description lines are blank to report patient revenue accounts not meeting the account descriptions included. Do not substitute for the account descriptions.

B Facility Trial Balance - Report amounts from the provider's trial balance. If a revenue account has a debit balance (a negative revenue) include brackets around the reported amount.

C Amount to Offset Cost - Report any amount included in the revenue which represents a recovery of a cost not related to covered long term care service. Do not report a revenue offset if the actual costs have been identified or adjusted through some other report process to remove the cost from the reimbursable amount. Using revenue offsets is a short cut to removing the corresponding cost. The provider must be able to show that the offset used is representative of the corresponding cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

D Part 3 Line Number to Offset - Report the line number from Schedule B, Part 3 where the offset applies. Part 3 includes lines to apply offsets to categories in total when the offset cannot be applied to a specific cost account.

Nebraska Medicaid Patient Revenues - Report the patient revenues related to residents covered by the Nebraska Medicaid Program. The revenue for services includes ALL payments received from all sources for those residents. Revenue reported in this section is NOT limited to the State payment.
Private LTC Patient Revenues - Report the patient revenues related to long term care residents who are responsible for independent payment of the provider established rates. Do not report the portion of the Medicaid rate paid by the Medicaid resident. That amount must be included in the Medicaid Revenue section.

Other Payor LTC Patient Revenues - Report the patient revenues related to long term care residents covered by other long term care service programs, (i.e., another State's Medicaid, Medicare, Veterans, Hill-Burton, or others) in this section.

Other than LTC Patient Revenues - Report revenue from all other inpatient services in this section. This would include every type of patient service for residents not included in the long term care revenues. Report other patient revenues not meeting the descriptions on lines 98 through 110. Do not include revenue related to long term care service on these lines.

Complete all total lines. Report the grand totals on Line 112. Transfer the amount from Column B, Line 112 to Schedule B, part 4, Line 1.

DO NOT REPORT MORE THAN ONE AMOUNT IN AN ENTRY AREA.

INDICATE NEGATIVE AMOUNTS WITH BRACKETS.

DO NOT USE LINES 15 TO 28, 43 TO 56, AND 71-84.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS. If the blank lines are not adequate to report all the accounts from the provider's trial balance, write in "SEE ATTACHMENT ##", list the accounts on the attachment and show the total amounts on the form. All offsets must be reported on the form. Report a line number to offset for each amount to be offset.

If more than one line is to be offset, use the blank lines, reference the source line in the account description column, and record the offsets in Columns C and D.

12-012.09C Schedule B, Part 2, Other Revenue, Description: Part 2, located on page 5 of the report form, is used to report all other revenue recorded on the provider's trial balance, and any amount in the accounts that should offset cost.

12-012.09D Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category/Account Description - The column includes descriptions for common revenue accounts. Several lines are blank for other revenue accounts not meeting the descriptions included on the form. Do not substitute for the account descriptions.
B  Facility Trial Balance - Report the amount recorded in the provider's trial balance. If a revenue account has a debit balance (a negative revenue) include brackets around the reported amount.

C  Amount of Offset Cost - Report any amount included in the revenue which represents a recovery of a cost not related to covered long term care services. Do not report a revenue offset if the actual costs have been identified and adjusted through some other report process to remove the cost from the reimbursable amounts. Using revenue offsets is a short cut to removing the corresponding costs. The provider must be able to show that the offset used is representative of the corresponding cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

For account descriptions included on the form, two lines are included for reporting offsets related to the revenue. These are provided in order to apply the offset to more than one cost center. If additional lines are needed to complete the offset, use Lines 19 through 46.

D  Part 3 Line Number to Offset - Report the Schedule B, Part 3 line number where the offset applies. Part 3 includes lines to apply offsets to categories in total when the offset cannot be applied to a specific account.

If additional lines are needed write "See Attachment ##" in Column A, attach a summary, and record the totals from the attachment on the form. Each amount to be offset must be identified on the form. Therefore, allow space to record the related offsets by line when transferring summary information from the attachment to the form.

Offset unidentified or miscellaneous revenues to Schedule B, Part 3, Line 185.

Add the amounts in Columns B and C and enter the total on Line 47. Transfer amount from Column B to Schedule B, Part 4, Line 2.

DO NOT REPORT MORE THAN ONE AMOUNT IN AN ENTRY AREA.

INDICATE NEGATIVE AMOUNTS WITH BRACKETS.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS.

REPORT A LINE NUMBER TO OFFSET FOR EACH AMOUNT TO BE OFFSET.

12-012.09E  Schedule B, Part 3, Costs and Allocations, Description: Part 3, located on pages 6 through 14 of the report form, is used to report all costs from the accounting records. The revenue offsets are summarized. The cost report adjustments are summarized. The allocations to the reimbursable and nonreimbursable cost centers are completed. The provider identifies the reimbursable costs which the Department will use to set the rate.
12-012.09F Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Line No. - The line numbers provide reference to the account descriptions. They are used in other schedules to relate offsets and adjustments to the appropriate lines of this part of Schedule B. Offsets and adjustments recorded on the other schedules include columns to identify the "Part 3 line number". Use the line numbers from this column to make those references.

Cost Category/Account Description - The cost categories are provided to identify the grouping of the accounts. Because of the various limitations and calculations used in setting rates, COSTS MUST BE REPORTED IN THE PROPER REPORT CLASSIFICATION.

Each category includes several account descriptions. Most categories include blank lines for accounts not fitting the descriptions. In addition, the categories include a line to report costs that are not reimbursable and a line to summarize the category revenue offsets. Do not substitute for the account descriptions on the form. Do not include costs for therapies, other than respiratory, after December 31, 1991.

B Facility Trial Balance - Report the amount from the trial balance for each applicable account description. If the cost account has a credit balance (a negative cost), include brackets to indicate the negative amount.

C Revenue Offsets - Summarize the revenue offsets reported on Parts 1 and 2 of Schedule B. Offsets are normally reductions of the cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

D Cost Report Adjustments - Summarize the cost report adjustments reported on Schedules B-1, B-2, B-3, and B-4. The adjustments in this column decrease the cost unless the amount is recorded with brackets.

E Cost For Allocation - Subtract the revenue offsets and cost report adjustment amounts from the trial balance amount and record the difference in this column.

F Allocation Basis No. - Record the basis number from Schedule B-5 which is to be used to allocate the amount in Column E. EACH LINE WITH AN AMOUNT IN COLUMN E MUST HAVE AN ALLOCATION BASIS INDICATED IN THIS COLUMN. Use 1 if the entire account is NF, 3 if the account is all nonallowable/other, and 0 if specific accounting is used to identify the cost for the NF or nonallowable/other. Use -0- in this column if the distribution to the cost centers is based on actual costs identified in the records. Allocation methods other than 0, 1, or 3 must be approved by the Department before use. Costs not reported in the proper report classification must use allocation basis 3.
G  Allowable Long Term Care - Report the cost distribution for amounts related to the nursing facility. The distribution must be computed according to the allocation basis indicated in Column F. THE AMOUNTS IN COLUMN 'G' MUST REPRESENT ONLY THE NF PORTION OF COSTS ALLOWABLE FOR REIMBURSEMENT.

H  Unallowable and Other - Report the cost distribution for amounts not related to NF. The distribution must be computed according to the allocation basis indicated in Column F.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS ON THE FORM.

DO NOT REPORT MORE THAN ONE ITEM IN AN ENTRY AREA.

REPORT AN ALLOCATION BASIS NUMBER FOR EACH LINE INCLUDING AN AMOUNT TO ALLOCATE.

12-012.09G Schedule B, Part 4, Revenue and Cost Summary, Description: Part 4, located on page 15 of the report form, is used to summarize the revenue and cost information and report the net revenue or loss for the provider. Most of the information for this part of the Schedule is obtained from other lines in Parts 1, 2, and 3 of Schedule B.
Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category - The category describes the information to be reported in Column B.

B Amount - Report the corresponding trial balance totals from Parts 1, 2, and 3 or the other information indicated below.

1 Total Patient Revenue - Report the amount from Part 1, Column B, Line 112.
2 Total Other Revenue - Report the amount from Part 2, Column B, Line 47.
3 Total Revenue - Add the amounts on Lines 1 and 2 and report on this line.
4 Administration - Report the amount from Part 3, Column B, Line 34.
5 General - Report the amount from Part 3, Column B, Line 45.
6 Dietary - Report the amount from Part 3, Column B, Line 63.
7 Housekeeping - Report the amount from Part 3, Column B, Line 78.
8 Laundry - Report the amount from Part 3, Column B, Line 93.
9 Nursing - Report the amount from Part 3, Column B, Line 128.
10 Plant - Report the amount from Part 3, Column B, Line 163.
11 Activities and Social Services - Report the amount from Part 3, Column B, Line 184.
12 Total Operating Cost - Add the amounts on Lines 4 through 11 and record the total on this line.
14 Total Fixed Cost - Report the amount from Part 3, Column B, Line 249.
15 Total Cost Centers-Not Reimbursable - Report the amount from Part 3, Column B, Line 258.
16 Total Costs - Add the amounts on Lines 12 through 15 and record the total on this line.
17 Net Income Before Tax - Subtract Line 16 from Line 3 and record the difference on this line.
18 Income Tax Provision - If applicable, report the income tax provision as recorded on the records of the provider.

19 Net Income After Tax - Subtract Line 18 from Line 17 and record the total on this line.

Do not report more than one amount for any one entry area.

12-012.09J Schedule B-1, General Cost Allocation and Adjustment, Description: Schedule B-1, located on page 16 of the report form, is used to complete the allocation of the costs reported in the general cost category.

12-012.09K Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-1.

A Payroll Category - These are the payroll account descriptions included in Schedule B, Part 3.

B Salaries, Wages, Other Compensation Reported - Report the amounts on this line that are reported for the corresponding account descriptions in Schedule B, Part 3. If any adjustments are made to the salary accounts before completion of this form, include the adjusted amounts in this column.

C Exemption - Report any adjustment to the salary needed to set a reasonable basis for the allocation of the FICA tax. This column relates primarily to situations where individual payrolls have exceeded the maximum used for FICA tax.

D Allocation Basis - Report the salary, etc., from Column B, adjusted by the amounts in Column C.

E Percentage - Divide each line of Column D by the total of that column and record the percentage in this column. Round all percentages to the nearest hundredth of a percent.

F Adjustment - Multiply the percentage in Column E by the total FICA tax reported on Schedule B, Part 3, Line 35, and record the result in this column.

G Line Number to Adjust - The form includes the payroll tax line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

H Exemption - Report amounts in this column needed to adjust the salaries, etc., in Column B to an equitable allocation base for other payroll taxes.

I Allocation Basis - Report the salary, etc., from Column B, adjusted by the amounts in Column H.
J  Percentage - Divide each line of Column I by the total of that column and record the percentage in this column.

K  Adjustment - Multiply the percentage in Column J by the total other payroll tax reported on Schedule B, Part 3, Line 36, and record the result in this column.

L  Line Number to Adjust - The form includes the payroll tax line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

M  Percentage - Divide each line of Column B by the total of that column and record the percentage in this column.

N  Adjustment - Multiply the percentage in Column M by the allowable benefits included on Schedule B, Part 3, Lines 37 through 43, and record the result in this column.

O  Line Number to Adjust - The form includes the fringe benefits line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

THE TOTAL OF THE ADJUSTMENT COLUMNS MUST AGREE WITH THE CORRESPONDING AMOUNTS IN THE GENERAL COST CATEGORY ON SCHEDULE B, PART 3. NO REIMBURSEMENT IS COMPUTED FOR ANY COSTS REMAINING IN THE GENERAL COST CATEGORY.

Summarize the adjustments from this schedule, along with those from Schedules B-2, B-3, and B-4, in Column D of Schedule B, Part 3.

12-012.09L  Schedule B-2, Transactions with Related Organizations, Report and Adjustments, Description: Schedule B-2, located on page 17 of the report form, is used to report ALL related organization transactions included in the operating and ancillary cost categories and to determine the related adjustments.

12-012.09M  Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-2.

A  Name of Related Organization or Individual - Report the name of the related organization or the individual.

B  Percent of Ownership, Related Organization in Nursing Home - Report what portion of the provider is owned by the related organization.

C  Percent of Ownership, Nursing Home in Related Organization - Report what portion of the related organization is owned by the provider.

D  Common Owners, Percent Ownership in Nursing Home - Determine the individuals or organizations that have ownership in both the related organization and the provider. Report the total share of the provider owned by those individuals and organizations.
E  Common Owners, Percent Ownership in Related Firm - Determine the individuals and organizations that have ownership in both the related organization and the provider. Report the total share of the related organization owned by those individuals and organizations.

F  Purchases from Related Organization in the Amount Of - Report the total amount of the transactions with the related organization or individual. Complete one line for each line of Schedule B, Part 3 that includes related party transactions.

G  Cost to Related Organization of Services/Items Purchased - Report the original cost to the related organization. If the related organization qualifies for the exception to the limitation, do not report the cost. Instead, write the word "exception" in this column.

H  Amount to (Increase) Decrease - Subtract the amount in Column G from the amount in Column F and record the difference in this column. If the exception applies, report zero in this column.

I  Line Number - Report the Schedule B, Part 3 line number where the adjustment applies. If there is no adjustment, report the line number from Schedule B, Part 3 that includes the transaction.

Summarize the adjustments from this schedule, along with those from Schedules B-1, B-3, and B-4, in Column D of Schedule B, Part 3.

Copies of this form may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 20.

12-012.09N  Schedule B-3, Compensation of Owners, Directors and Other Related Parties, Report and Adjustment, Description: Schedule B-3, located on page 18 of the report form, is used to report ALL compensation paid to owners, directors, and other individuals related to owners or directors. Compensation includes salary, benefits, and services or items paid by the provider which are for the personal use of an individual. The schedule is used to adjust the compensation paid to owners, directors, and related parties to the amount for reimbursement.

12-012.09P  Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-3.

A  Name of Individual - Report the name of every owner, director, or related party who receives compensation from the provider. If the individual holds more than one position, that is, his/her compensation is reported in more than one payroll category on Schedule B, Part 3, use separate report lines on this schedule for each position.
B  Position - Report the paid position the individual holds at the facility. Attach specific job descriptions for each position listed.

C  Documented Percentage of 40 Hour Work Week - Report the average percentage of a 40 hour week that the individual has DOCUMENTED performance of the duties assigned to the position.

D  Percentage Owned - If the individual owns a portion of the provider, report the percentage of ownership in this column. Also, note the relationship, board position, or other reason that the individual is listed on the schedule.

E  Account - Record the account descriptions from Schedule B, Part 3 where the compensation is reported. Each line includes space to report five accounts. Three of the spaces relate to payroll, payroll tax, and fringe benefits. Two spaces are provided to report compensation paid in other forms, i.e., automobile, housing, supplies, meals, etc.

F  Amount Per Trial Balance - Report the compensation amount reported on Schedule B, Part 3.

G  Amount Allowable - Based on the documented services provided, report the reasonable amount of compensation to be allowed. The allowable compensation is the usual amount paid for similar positions at the facility or for similar positions outside the facility. The amounts in this column must not exceed the amounts in Column F for the position.

H  Amount to Decrease Cost - Subtract the amount in Column G from the amount in Column F and record the difference in this column.

I  Line Number - Report the Schedule B, Part 3, line number where the adjustment applies. If there is no adjustment, report the line number from Schedule B, Part 3, that includes the compensation.

Summarize the adjustments from this schedule, along with those from Schedule B-1, B-2, and B-4, in Column D of Schedule B, Part 3.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 20.

12-012.09Q Schedule B-4, Other Cost Adjustments. Description: Schedule B-4, located on pages 19 and 20 of the report form, is used to report cost adjustments needed to change the trial balance costs to the amounts allowable for reimbursement.
12-012.09R Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-4.

A Adjustment Descriptions - Adjustment descriptions are provided on the first page of the schedule. Lines 1 through 17 describe some of the common Medicaid reimbursement adjustments. Lines 18 through 23 describe the fixed cost adjustments determined on other schedules of the report. The descriptions for these six lines include a reference to the adjustment's source schedule.

On the second page of the schedule, the Adjustment Description column is blank. Use these lines to report any other adjustments, increases, decreases, or reclassifications needed to complete the process of revision of the trial balance to the allowable cost for allocation. (Report an adjustment description, not the account description.)

B Amount to Increase Cost - Report the adjustment amount in this column if it increases the reported cost.

C Amount to Decrease Cost - Report the adjustment amount in this column if it decreases the reported cost.

D Line Number to Adjust - Report the line number from Schedule B, Part 3, where the adjustment amount in Column B and/or C applies.

If a revenue offset has been used to adjust for an unallowable cost, and the revenue offset covers the cost incurred, that cost does not need to have an adjustment on this form.

Summarize the adjustments from this schedule, along with those from Schedules B-1, B-2, and B-3, in Column D of Schedule B, Part 3.

Copies of the second page of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 100.

12-012.09S Schedule B-5, Statistical Data For Allocations, Description: Schedule B-5, located on page 21 of the report form, is used to report the allocation bases used for the allocation of costs between the NF and other cost centers. The statistics and resulting percentages reported on this schedule are used to distribute the costs on Schedule B, Part 3, Columns G and H.

12-012.09T Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-5.

A Basis No. - The numbers in this column, 0 through 31, are of major importance in the report process. They are used to complete Column F on Schedule B, Part 3, for each line that has cost to allocate.
B  Allocation Basis - This column describes the basis used for the allocation. Basis 0 indicates that the provider's records will identify the reported distribution, thus no allocation was necessary. Bases 1 and 3 indicate that 100% of the costs relate to one cost center; NF, or Other, respectively. Bases 4 through 9 are commonly used allocation bases but are not required to be used. The remaining lines are left for the provider to identify other allocation bases selected.

C  Statistics for Allocation, Total - Report the total of the statistic base. Report the statistics on the top portion of each basis line. Report the percentage on the bottom portion of each basis line. For this column, the percentage is 100.00%.

D  Statistics for Allocation; NF and Other - On the top portion of the basis line report the breakdown of the statistics used for allocation. Compute the percentage each cost center's statistics are of the total statistical base and record the percentage in the bottom portion of the basis line.

ROUND THE PERCENTAGES TO ONE HUNDREDTH OF A PERCENT.

If an allocation basis is more complex than the straight one line statistical basis, write "See Attachment ##" on the description line. Show the statistics and computations used to determine the allocation on the attachment. Record the percentages on both portions of the basis line of the form.

Do not use more bases than the blank lines permit.

Allocation bases used must be consistent from year to year unless a change is approved or directed by the Department.

All allocation bases must be approved by the Department before the Report Period.

12-012.10  Schedule C, Comparative Balance Sheet, Description: Schedule C, located on page 22 of the report form, is used to report the assets, liabilities, and equity of the provider. The schedule includes the prior year and current year information.

12-012.10A  Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule C.

A  Assets, Liabilities, and Equity - This column provides the account descriptions for the balance sheet accounts. Some lines have been left blank to add accounts not listed.

B  Previous Year Ending - Record this column as it appears on the prior report period's cost report form. Note any variance from the prior year's report in the preparer's report.

The reported data must reflect the provider's balance sheet. If the provider's balance sheet is part of a consolidation of several entities, the long term assets and liabilities must be reported for the provider with a balancing intercompany entry for equity. Beginning with the report period beginning July 1, 1986, the provider's portion of the balance sheet must be broken out from the consolidated statement and reported.

12-012.11 Schedule D, Part 1, Depreciation Cost, Description: Schedule D is a three-part schedule located on pages 23 and 24 of the report form.

Part 1, located on page 23 of the report form, is used to report the fixed assets recorded on the trial balance and summarize the adjustments needed to change the trial balance fixed asset cost to include only the nursing facility assets. It is also used to report the appropriate depreciation and to compute the adjustment to correct the trial balance depreciation.

The schedule includes summary data. The depreciation schedule maintained at the facility must provide the detail that identifies each fixed asset and the related depreciation.

12-012.11A Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule D.

A Description of Property - This column provides the identification of the asset groups to be reported. Several asset group titles are on the schedule. Other lines are blank for other groupings according to the trial balance.

B Date Acquired - Report the date that the property was acquired by the provider. This column only needs to be completed on the lines for the original assets.

C Trial Balance - Report the balance sheet cost amount for each of the asset groups. This column must agree with the balance sheet reported on Schedule C.

D Cost Adjustment - The adjustments reported on Schedule D-1 are summarized and reported in this column. The adjustments are considered a cost reduction unless the amount is recorded with brackets.

E Cost, Long Term Care Value - Subtract the cost adjustments in Column D from the trial balance amounts in Column C and record the difference in this column.

F Salvage Value - Report any salvage value expected at the end of the assigned useful life.

G Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight-line method.
H Useful Life - The useful lives assigned for reimbursement purposes must follow the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition (see 471 NAC 12-011.09). (IRS accelerated cost recovery system lives do not qualify for "depreciation" for Medicaid reimbursement purposes.) Report lives as years.

I Not used on this part of the schedule.

J Prior Years Depreciation - Report the accumulated depreciation as of the beginning of the report period. Report the amount based on Medicaid values.

K Depreciation Cost - Report the depreciation for the report period. Subtract the amount in Column F from the amount in Column E and divide the difference by the assigned life. For partial years, prorate the annual amount.

L Medicaid Book Value - The long term care cost value minus the accumulated Medicaid depreciation cost for the assets that remain in use at the end of the report period.

Transfer the cost of leased items from Schedule E, Part 1 to Line 27. Add amounts in each column and record the totals on Line 28. Transfer the depreciation cost from the trial balance to Line 29 of Column K. The trial balance depreciation cost is reported on Schedule B, Part 3, Column B, Line 233. In Column J, subtract the amount reported on Line 29 from the amount reported on Line 28 and record the difference on Line 30. Transfer this amount to Schedule B-4 as indicated on the form.

12-012.11B Schedule D, Part 2, Cost Report Period Additions, Description: Part 2, located on page 24 of the report form, is used to report the depreciation schedule information for fixed assets added during the report period.

12-012.11C Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by additional information about this part of Schedule D.

A Item Description - Report the specific description of the asset that has been added. This may not be reported in summary form except when identical assets are purchased in one lot on the same day. In such a case, include the number of items.

B Date Acquired - Report the date that the item was purchased or acquired.

C Not used in this part.

D Useful Life - Report the useful life used for Medicaid reimbursement purposes.
E  Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight-line method.

F  Original Cost - Report the asset cost included in Column E of Part 1 as a result of acquisition of the fixed asset.

G  Salvage Value - Report any salvage value expected at the end of the assigned useful life.

H  Current Year Depreciation Cost - Report the depreciation as computed for Medicaid purposes. Subtract the salvage value, Column G, from the original cost, Column F, and divide by the number of years useful life, Column D. For partial years, prorate the annual amount.

I  Not used for this part.

J  Schedule D, part 1, Line Number - Report the line number where the new addition is included on the Depreciation Schedule Summary, Schedule D, Part 1.

Add all amount columns and record the total on the total line.

Copies of this part of the schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the page.

FIXED ASSET ADDITIONS MUST BE REPORTED ON THIS PART OF THE SCHEDULE IN ORDER FOR DEPRECIATION TO BE ALLOWED.

12-012.11D Schedule D, Part 3, Current Report Period Deletions, Description: Part 3, located on page 24 of the report form, is used to report the depreciation schedule information for fixed assets removed from long term care during the report period.

12-012.11E Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by additional information about this part of Schedule D.

A  Item Description - Report the specific description of the asset that has been removed from service. Each item must be identified separately.

B  Date of Acquisition - Report the date the fixed asset was originally acquired.

C  Date of Disposal - Report the date the item was no longer used for long term care.
Useful Life - Use the American Hospital Association guidelines to determine useful lives.

Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight line method.

Original Cost - Report the asset cost used for Medicaid depreciation.

Salvage Value - Report the amount that had been carried on the depreciation schedule as the salvage value.

Current Year Depreciation Cost - Report the depreciation from the beginning of the report period to the date that the asset was no longer in use for long term care.

Accumulated Depreciation - Report all depreciation which has accumulated from the date of acquisition to the date the time was removed from service for long term care.

Schedule D Part 1 Line Number - Report the line number where the item removed will be deleted from the Depreciation Schedule Summary, Schedule D, Part 1.

Add all amount columns and record the totals on the total line.

FIXED ASSET DELETIONS MUST BE REPORTED ON THIS SCHEDULE IN ORDER FOR THE PAST DEPRECIATION TO BE ALLOWABLE.

Copies of this part of the schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the page.

12-012.12 Schedule D-1, Depreciation Schedule Adjustments, Description: Schedule D-1, located on page 25 of the report form, is used to itemize and describe the adjustments used to adjust the facility trial balance fixed asset cost to the amount allowed. It is also used to make adjustments to reclassify fixed asset categories.

12-012.12A Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule D-1.

Adjustment Description - Report the reason for each adjustment. Do NOT report only the item description or property category to be adjusted.

Amount to Increase Cost - Report the adjustment amount to increase the fixed asset cost on Schedule D, Part 1.
C  Amount to Decrease Cost - Report the adjustment amount to decrease the fixed asset cost on Schedule D, Part 1.

D  Schedule D Line to Adjust - For each adjustment increase and/or decrease reported in Columns B and C, report the line number on Schedule D, Part 1 that is to be adjusted.

After completing the adjustments, summarize the adjustments on Schedule D, Part 1, Column D.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule.

12-012.13  Schedule E, Interest Cost, Description: Schedule E is a two-part schedule located on pages 26 and 27 of the report form.

12-012.13A  Schedule E, Part 1, Loans and Interest Cost Summary, Description: Part 1, located on page 26 of the report form, is used to report the loan information for all loans included on the trial balance and adjustments needed to change the trial balance to include only the allowable loans. It is also used to determine the adjustments necessary to adjust the trial balance interest cost to the amount allowable for reimbursement.

12-012.13B  Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule E.

A  Source/Security and Purpose - This column includes three items of information for each loan:

Source - Report the lending institution or individual who made the loan to the provider. If the loan is a bond issue, report the type of bond issue (i.e., revenue bonds, industrial development bonds, etc.).

Related Parties (X) - Mark this box if the source of the loan is related to the provider through common ownership or control as defined by the regulations.

Security and Purpose - Report the security pledged for repayment (i.e., mortgage, real property (describe), or personal property (describe), or as a "signature loan"). REPORT THE PURPOSE OF THE LOAN (i.e., to finance purchase of assets, to provide operating funds, to build an addition, to pay taxes, etc.). If additional space is needed to report the security and purpose, include the information on an attachment.
B  Date of Origin/Date Mature - This column includes two items of information for each loan:

  Date of Origin-Report the date the loan was obtained.
  Date Mature-Report the date that the loan becomes due or the date the final installment is due.

C  Original Loan Amount - Report the amount borrowed at the Date of Origin. If the loan has a floating balance such as a line of credit, report the highest balance for the report period.

D  Interest Rate - Report the interest rate as specified in the conditions of the loan. In cases of variable interest loans, mark a "V" in the box at the left of the column and report the final rate effective for the report period.

E  Adjusted Beginning Balance - Report the loan balances as they appeared on the prior year cost report "Adjusted Ending" column. If the loan originated during the report period, enter 0 in this column.

F  Ending Loan Balance - Report the loan amount as they appear on the trial balance. If a loan was paid off during the report period, report 0 in this column.

G  Adjustments - The loan balance adjustments reported on Schedule E-1 are summarized and reported in this column. The adjustments are considered a loan reduction unless the amount is recorded with brackets.

H  Adjusted Ending - Subtract the amount in Column G from the amount in Column F and record the difference in this column.

I  Not used on this part of the schedule.

J  Interest Cost, Paid to Unrelated Parties - Report the allowable interest in this column. If the full interest amount for a loan is not allowable, report the allowable portion in this column. The unallowable portion is reported in Column L.

K  Interest Cost, Paid to Related Parties - Report the interest paid and/or accrued on the loans from parties related to the provider by common ownership or control. The loan balance for these loans are included in the adjustments in Column G.

L  Interest Cost, Non-Nursing Facility Operations - Report the interest paid and accrued on loans which are not related to the nursing facility. The loan balances for these loans are included in the adjustments recorded in Column G. Also report the unallowable portion of the interest cost for loans which are otherwise allowable.
Transfer the lease cost information from Schedule F, Part 1, to Line 10. Add the amount columns and record the totals on Line 11. Provide a breakdown of the loans, as indicated, for Lines 12, 13, and 14.

Transfer the totals of Columns K and L to Schedule B-4 as indicated on the form.

Copies of this form may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. If additional copies are used, record the total for ALL copies on the last copy. Do not complete Lines 10 through 14 except on the final copy.

Attach one copy of the signed loan agreement for all loans originated or refinanced during the Report Period.

12-012.13C Schedule E, Part 2, Interest Limitation Computation, Description: Part 2, located on page 27 of the report form, is used to compute the interest limitation required when interest bearing loans exceed 80% of the cost of the fixed assets used for patient care. Two options are available for the computation. Option 1 bases the limitation on the year end loan and asset balances. Option 2 bases the limitation on monthly balances. A provider may change from Option 1 to Option 2 for any report. After Option 2 is selected for any report period, it must be used for all subsequent reports, unless a change is approved by the Department.

Government-operated providers do not need to complete Part 2. They are not subject to the limitation. (Government operated providers MUST complete Part 1.)

12-012.13D Definitions: Definitions of the data requested on this part of Schedule E follow:

OPTION 1: ANNUAL AVERAGE - The definitions are given for each line.

1. Record the ending loan balance from Schedule E, Part 1. The line reference is indicated on the form.

2. Record the asset cost from Schedule D, Part 1. The line reference is indicated on the form.

3. If the asset cost was decreased because of a change of ownership on or after December 1, 1984, determine the amount of the adjustment which would otherwise be allowed. Record that amount on this line.

4. Add Line 2 to Line 3 and record the total on this line.

5. Multiply the amount on Line 4 by 0.80 and record the result on this line.
6. Subtract the amount on Line 5 from the amount on Line 1 and record the difference on this line. If the amount is zero or a negative amount, do not complete the remainder of the form. If it is a positive amount, continue with Line 7.

7. Record the beginning loan balance from Schedule E, Part 1. The line reference is indicated on the form.

8. Record the ending loan balance from Schedule E, Part 1. The line reference is indicated on the form. (This is the same as the amount on Line 1.)

9. Compute the average loan balance. Add the amount on Line 7 and the amount on Line 8 and divide the total by 2. Record the result on this line.

10. Record the interest paid to unrelated parties from Schedule E, Part 1. The line reference is indicated on the form.

11. Compute the average annual interest rate. Divide the amount on Line 10 by the amount on Line 9. Record the result on this line.

12. Compute the amount of the limitation. Multiply the rate from Line 11 by the amount on Line 6. Transfer the limitation to the Schedule B-4 as indicated on the form.

OPTION 2 - MONTHLY AVERAGE - The definitions for the columns are followed by additional information about Option 2.

A Date - This column indicates the date that loan information and limitations are to be calculated. If the report is completed for less than the full 12 months, complete only the applicable months. Report the beginning amounts for a report period on Line 1, even if starting on another date. Write the correct beginning date on the line.

B Total All Interest Bearing Loans - Report the total loans that accrue interest.

C Total Related Party Interest Bearing Loans - Report the loans with related parties included in the amount reported in Column B.

D Total Non-Nursing Home Loans - Report the loans not related to the long term care which are included in Column B.

E Allowable Loan Balances - Add the amount in Column C to the amount in Column D. Subtract the total from the amount in Column B. Record the result in this column.
F  Cost of Fixed Assets Related to Care - Report the total cost of fixed assets as determined for Medicaid reimbursement. When determining the asset cost for Medicaid reimbursement, do not consider fixed asset cost limitations that are solely the result of 471 NAC 12-011.06H and J.

G  80% of Asset Cost - Multiply the amount in Column F by 0.80 and record the result in this column.

H  Loan Balance Over 80% of Asset Cost - Subtract the amount in Column G from the amount in Column E and record the difference in this column. IF THE RESULT IS NEGATIVE, REPORT -0-, NOT THE NEGATIVE AMOUNT.

I  Average Interest Rate - Complete Lines 14 through 18 as follows:

14  Add amounts in each column and record the total on this line.

15  Compute the average monthly loan balance. Divide the amount from Column E, Line 14, by the number of dates reported. Record the result on this line in Column E. Also record the result on Line 17.

16  Record the interest paid to unrelated parties as determined on Schedule E, Part 1. The line reference is indicated on the form.

17  Record the amount from Column E, Line 15 on this line.

18  Compute the average rate of interest. Divide the amount on Line 16 by the amount on Line 17. Record the total on this line.

Record the average rate of interest from Line 18 on all lines of Column I.

J  Interest Adjustment - Compute the interest limitation for the month. Multiply the amount in Column H by the rate in Column I. Divide the result by the number of months covered by the cost report and record the result in this column.

Add the amounts in Column J and record the total on Line 14. Also record the result on Schedule B-4 as indicated on the form.

Use of Option 2 requires the provider to maintain detailed accrual records on a monthly basis.
12-012.14 Schedule E-1, Loan Schedule Adjustments, Description: Schedule E-1, located on page 28 of the report form, is used to itemize and describe the adjustments used to adjust the ending loan balances to the amounts used for reimbursement.

12-012.14A Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule E-1.

A Adjustment Description - Report the reason for each adjustment in this column. Do NOT report only the loan source to be adjusted.

B Increase of Loan Amount - Report the adjustment amount to increase the loan amount on Schedule E, Part 1.

C Decrease of Loan Amount - Report the adjustment amount to decrease the loan amount on Schedule E, Part 1.

D Sch. E Part 1 Line to Adjust - For each adjustment increase and/or decrease reported in Columns B and C, report the line number from Schedule E, Part 1 which is to be adjusted.

After completing the adjustments, summarize the adjustments and record the totals on Schedule E, Part 1, Column G.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule.

12-012.15 Schedule F, Leases, Description: Schedule F is a two-part form located on pages 29 and 30 of the report form.

12-012.15A Schedule F, Part 1, Leases and Lease Adjustments, Description: Part 1, located on page 29 of the report form, is used to report information regarding all fixed long term leases included in the provider's fixed costs. The information reported on Line 5 determines if Part 2 and the remainder of the column is completed for any lease. This part also summarizes information from all copies of Part 2 and the resulting adjustments.

12-012.15B Definitions: Definitions of the data requested for this part of the schedule follow. Line definitions are followed by other information about this part of Schedule F.

1 Assigned Lease Number - Chronologically number the columns used to report on the leases. One column must be completed for each lease agreement.

2 Leasing Company or Individual - Report the name of the lessor as it appears on the lease agreement.
3 Items Leased - Describe the leased item or items. If the lease covers many items, use a summary description.

4 Cost Included on Trial Balance - Report the amount included in the lease costs reported on Schedule B, Part 3. (Do not report non-nursing facility leases. Such leases should be removed from the trial balance amount by adjustments on Schedule B-4.)

5 Mark the first line, 5a through 5e, that applies to the lease.

5a Related Organization - Mark the line if the lessor is related to the provider through common ownership or control as defined in the regulations.

5b Facility Leased after 7/31/82 - Mark this line if the lease agreement is subject to limitation according to 471 NAC 12-011.06E. The regulation refers to facilities leased after July 31, 1982.

5c Lease Purchases - Mark this line if the lease agreement is a lease/purchase agreement as defined in the Provider Reimbursement Manual HIM-15, Section 110.

5d Sale and Lease Back - Mark this line if the lease agreement involves a sale and lease back by the seller.

5e Other - Mark this line if 5a, 5b, 5c, and 5d do not apply to the lease.

If 5a, 5b, 5c, or 5d is marked, Part 2 must be completed for the lease. Part 2 must be completed before Lines 6 through 18 can be completed for the lease.

If line 5e is marked, do not complete Part 2 or lines 6 through 18.

Lines 6 through 18 summarize information on leases subject to ownership cost limitations. Develop the data for an individual lease by completing Part 2.

6 Cost to Reduce, Building and Perm. Equipment Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2, that is for building and permanent equipment.

7 Cost to Reduce, Vehicle Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2 that is for a vehicle.

8 Cost to Reduce, Other Long Term Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2 that is for other long term leases.
Cost to Allow, Depreciation - If the owner's cost is substituted for the lease, record the total depreciation amount from Part 2, Item 4.

Cost to Allow, Interest - If the owner's cost is substituted for the lease, record the total interest amount from Part 2, Item 5.

Cost to Allow, Other - If the owner's cost is substituted for the lease, record the other amounts by account description from Part 2, Item 6.

Other Ownership Data, Asset Cost - If owner's cost is substituted for the lease, record the total asset cost from Part 2, Item 4.

Other Ownership Data, Beginning Loan Balance - If owner's cost is substituted for the lease, record the total beginning balance from Part 2, Item 5.

Other Ownership Data, Ending Loan Balance - If owner's cost is substituted for the lease, record the total ending balance from Part 2, Item 5.

After completing all leases, add the amount lines and record the total in the last column of the last copy of Part 1. Also record the totals from Lines 6 through 18 on the other schedules as indicated at the end of each line on the form.

If any lease was originated, renegotiated, or otherwise changed during the Report Period, include one copy with the submitted reports.

This part of the schedule may be copied to expand the number of columns as needed. Record the copy number in the box at the bottom of the page.

12-012.15C Schedule F, Part 2, Ownership Cost, Description: Part 2, located on page 30 of the report form, is used to report information on each lease which may be subject to the ownership cost limitations. The use of this part depends on which item is marked on Schedule F, Part 1, Line 5. A short outline on the form indicates how to report the cost information for each of the four options. Complete this part for each lease marked on Schedule F, Part 1, Line 5a, 5b, 5c, or 5d. Copy the page as needed to report on subject leases.

12-012.15D Definitions: Definitions of the data requested for each item of this part of Schedule F follow.

1 Record the lease number assigned to this lease from Part 1, Line 1.

2 Record the cost reported for this lease. The amount will agree with the amount reported on Part 1, Line 4.
3 Complete only when 5b is marked on Part 1. Mark yes or no for each question. The three items are required for any cost to be allowed for a facility or facility/equipment lease entered into after July 31, 1982. If ANY of the questions are answered no, report -0- for all the totals in Items 4, 5, and 6. If ALL are answered yes, complete Items 4, 5, and 6.

4 Depreciation Schedule - Report the depreciation schedule data for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

5 Loans and Interest - Report the loan data for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

6 Other Costs - Report any other costs for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

Depending on the basis for completion of Part 2, transfer the totals and other amounts to Part 1, Lines 6 through 18.

12-012.16 Preparer Acknowledgement, Description: The preparer acknowledgement is located on the last page of the report form. This part must be completed by any person or firm that prepares the cost report. The acknowledgement, in and of itself, is not a "report" on the statements of the cost report. Reports issued by the preparer are part of the cost report and must be attached to the cost report.

The preparer of a cost report must be familiar with the Nebraska Medicaid reimbursement program and the long term care industry accounting principles and practices. The preparer must discuss potential disallowances with the provider's management. The preparer must, in the preparer's report, disclose known variances from the reporting and regulatory requirements included in the cost report preparation.

Instructions: Record the following information in the blanks:

- the "official" name of the provider organization, the name that appears on the current Nebraska Medicaid Provider Agreement.

- the provider number assigned by the Department.

If the preparer is a certified public accountant or accounting firm, indicate the type of report issued on the engagement.

Signature - The preparer signs the acknowledgement. Also print or type the name of the individual signing the acknowledgement.

Firm - Report the name of the firm contracted to prepare the report.

Date - Report the date the acknowledgement is signed.
12-012.17 Certification of Officer, Owner, or Administrator, Description: The certification is located on the last page of the report form. It is used by the provider’s management to attest to the accuracy of the cost report information provided to the Department. The person signing the report must be familiar with the Nebraska Medicaid Program’s reimbursement regulations and the provider's costs. The person signing the report indicates by signature, that she/he has reason to know what is included in the report and what cannot be included in the report.

Instructions: Record the following information in the blanks:

- the "official" name of the long term care provider organization, the name that appears on the current Nebraska Medicaid Provider Agreement.
- the provider number assigned by the Department.
- the beginning and ending date of the period covered by the cost report.

Signature - The provider’s owner, officer, or administrator signs the report. Also type or print the name in this box.

Title - Report the title of the individual signing the report.

Date - Report the date the report is signed.
12-013 Classification of Residents and Corresponding Weights

12-013.01 Resident Level of Care: The Department will use a federally-approved Resource Utilization Groups (RUG) grouper to assign each resident to a level of care based on information contained on his/her Minimum Data Set (MDS) assessment. Each level of care will be assigned the federally-recommended weight (see 471 NAC 12-013.04). When no MDS assessment is available, the resident will be assigned to a default level of care (Level 180).

12-013.02 Weighting of Resident Days Using Resident Level of Care and Weights: Each facility resident is assigned to a level of care per 471 NAC 12-013.01. Each resident’s level of care is appropriately updated from each assessment to the next – the admission assessment, a significant change assessment, the quarterly review, the annual assessment, etc., and is effective for payment purposes on the first day of the month of the applicable assessment if it is received by the tenth day of the month of the applicable assessment. A change in resident level of care which results from an audit of assessments (see 471 NAC 12-013.05) is retroactive to the effective date of the assessment which is audited.

For purposes of the Nebraska Medicaid Case Mix System, the Department does not change an assessment record. A record modification may replace an existing record in the Centers for Medicare and Medicaid Services (CMS) MDS data base, but the Department will not replace the existing record in the Nebraska Medicaid Case Mix system. The record modification will be processed by the Department as an original record. This means that the Department will process the record in the usual manner if the record is not already in the Case Mix system. The Department will reject the record as a duplicate if the record has already been accepted into the Case Mix system. The Department will inactivate a discharge or re-entry tracking record but not an assessment.

For each reporting period, the total resident days (per the MDS system) at each care level are multiplied by the corresponding weight (see 471 NAC 12-013.03). The resulting products are summed to determine the total weighted resident days per the MDS system. This total is then divided by the MDS total resident days and multiplied by total resident days per the facility’s Nebraska Medicaid Cost Report to determine the total number of Weighted Resident Days for the facility, which is the divisor for the Direct Nursing Component.
12-013.03 Resident Level of Care Weights: The following weighting factors shall be assigned to each resident level of care, based on the CMS RUG III 5.20 version.

<table>
<thead>
<tr>
<th>Level Of Care</th>
<th>Casemix Index Value</th>
<th>Casemix Index Description</th>
<th>Casemix Index Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>163 RAD</td>
<td>Rehabilitation/ADL = 17-18</td>
<td>1.66</td>
<td></td>
</tr>
<tr>
<td>162 RAC</td>
<td>Rehabilitation/ADL = 14-16</td>
<td>1.31</td>
<td></td>
</tr>
<tr>
<td>161 RAB</td>
<td>Rehabilitation/ADL = 9-13</td>
<td>1.24</td>
<td></td>
</tr>
<tr>
<td>160 RAA</td>
<td>Rehabilitation/ADL = 4-8</td>
<td>1.07</td>
<td></td>
</tr>
<tr>
<td>172 SE3</td>
<td>Extensive Services 3/ADL &gt;6</td>
<td>2.10</td>
<td></td>
</tr>
<tr>
<td>171 SE2</td>
<td>Extensive Services 2/ADL &gt;6</td>
<td>1.79</td>
<td></td>
</tr>
<tr>
<td>170 SE1</td>
<td>Extensive Services 1/ADL &gt;6</td>
<td>1.54</td>
<td></td>
</tr>
<tr>
<td>152 SSC</td>
<td>Special Care/ADL = 17-18</td>
<td>1.44</td>
<td></td>
</tr>
<tr>
<td>151 SSB</td>
<td>Special Care/ADL = 15-16</td>
<td>1.33</td>
<td></td>
</tr>
<tr>
<td>150 SSZ</td>
<td>Special Care/ADL = 4-14</td>
<td>1.28</td>
<td></td>
</tr>
<tr>
<td>145 CC2</td>
<td>Clinically Complex w/Depression/ADL = 17-18</td>
<td>1.42</td>
<td></td>
</tr>
<tr>
<td>144 CC1</td>
<td>Clinically Complex/ADL = 17-18</td>
<td>1.25</td>
<td></td>
</tr>
<tr>
<td>143 CB2</td>
<td>Clinically Complex w/ Depression/ADL = 12-16</td>
<td>1.15</td>
<td></td>
</tr>
<tr>
<td>142 CB1</td>
<td>Clinically Complex/ADL = 12-16</td>
<td>1.07</td>
<td></td>
</tr>
<tr>
<td>141 CA2</td>
<td>Clinically Complex w/Depression/ADL = 4-11</td>
<td>1.06</td>
<td></td>
</tr>
<tr>
<td>140 CA1</td>
<td>Clinically Complex/ADL = 4-11</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>133 IB2</td>
<td>Cognitive Impairment with Nursing Rehab/ADL = 6-10</td>
<td>0.88</td>
<td></td>
</tr>
<tr>
<td>132 IB1</td>
<td>Cognitive Impairment/ADL = 6-10</td>
<td>0.85</td>
<td></td>
</tr>
<tr>
<td>131 IA2</td>
<td>Cognitive Impairment with Nursing Rehab/ADL = 4-5</td>
<td>0.72</td>
<td></td>
</tr>
<tr>
<td>130 IA1</td>
<td>Cognitive Impairment/ADL = 4-5</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>123 BB2</td>
<td>Behavior Prob w/Nursing Rehab/ADL = 6-10</td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>122 BB1</td>
<td>Behavior Prob/ADL = 6-10</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>121 BA2</td>
<td>Behavior Prob w/Nursing Rehab/ADL = 4-5</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>120 BA1</td>
<td>Behavior Prob/ADL = 4-5</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>115 PE2</td>
<td>Physical Function w/Nursing Rehab/ADL = 16-18</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>114 PE1</td>
<td>Physical Function/ADL = 16-18</td>
<td>0.97</td>
<td></td>
</tr>
<tr>
<td>113 PD2</td>
<td>Physical Function w/Nursing Rehab/ADL = 11-15</td>
<td>0.91</td>
<td></td>
</tr>
<tr>
<td>112 PD1</td>
<td>Physical Function/ADL = 11-15</td>
<td>0.89</td>
<td></td>
</tr>
<tr>
<td>111 PC2</td>
<td>Physical Function w/Nursing Rehab/ADL = 9-10</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>110 PC1</td>
<td>Physical Function/ADL = 9-10</td>
<td>0.81</td>
<td></td>
</tr>
</tbody>
</table>

**Medicaid Waiver Assisted Living Levels of Care**

<table>
<thead>
<tr>
<th>Level Of Care</th>
<th>Casemix Index Value</th>
<th>Casemix Index Description</th>
<th>Casemix Index Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>104 PB2</td>
<td>Physical Function w/Nursing Rehab/ADL = 6-8</td>
<td>0.65</td>
<td></td>
</tr>
<tr>
<td>103 PB1</td>
<td>Physical Function/ADL = 6-8</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>102 PA2</td>
<td>Physical Function w/Nursing Rehab/ADL = 4-5</td>
<td>0.62</td>
<td></td>
</tr>
<tr>
<td>101 PA1</td>
<td>Physical Function/ADL = 4-5</td>
<td>0.59</td>
<td></td>
</tr>
</tbody>
</table>

**Default Rate – Used When No Assessment is Available**

<table>
<thead>
<tr>
<th>Level Of Care</th>
<th>Casemix Index Value</th>
<th>Casemix Index Description</th>
<th>Casemix Index Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>180 STS</td>
<td>Short Term Stay</td>
<td></td>
<td>0.59</td>
</tr>
</tbody>
</table>
*Level of Care 180 (Short-term stay) is used for stays of less than 14 days when a client is discharged and the facility does not complete a full MDS admission assessment of the client. This is effective for admissions on or after July 1, 2010.

12-013.04 Verification: Resident assessment information is audited as a procedure in the Department of Health and Human Services Division of Public Health Survey and Certification process.
12-014 Services for Long Term Care Clients with Special Needs

12-014.01 The term “Long term care clients with special needs” means those whose medical/nursing needs are complex or intensive and are above the usual level of capabilities of staff and exceed services ordinarily provided in a nursing facility as defined in 471 NAC 12-003.

12-014.01A Ventilator-Dependent Clients: These clients are dependent on mechanical ventilation to continue life and require intensive or complex medical services on an ongoing basis. The facility shall provide 24-hour R.N. nursing coverage.

12-014.01A1 Criteria for Care: The client must -

1. Require intermittent (but not less than 10 hours in a 24-hour period) or continuous ventilator support. S/he is dependent on mechanical ventilation to sustain life, or is in the process of being weaned from mechanical ventilation (this does not include individuals using continuous positive airway pressure (C-PAP) or Bi-level positive airway pressure (BiPAP) nasally; patients requiring use of Bi-PAP via a tracheostomy will be considered on a case-by-case basis);
2. Be medically stable and not require intensive acute care services;
3. Have care needs which require multi-disciplinary care (physician, nursing, respiratory therapist, psychology, occupational therapy, physical therapy, pharmacy, speech therapy, spiritual care, or specialty disciplines);
4. Require daily respiratory therapy intervention and/or modality support (for example: oxygen therapy, tracheostomy care, chest physiotherapy, deep suctioning, etc.); and
5. Have needs that cannot be met at a lesser level of care (for example: skilled nursing facility, regular nursing facility unit, assisted living, private home).

12-014.01B Clients with Brain Injury:

12-014.01B1 Clients Requiring Specialized Extended Brain Injury Rehabilitation: These clients must require and be capable of participating in an extended rehabilitation program. Their care must be -

1. Primarily due to a diagnosis of acute brain injury (see 471 NAC 12-001.04); or
2. Primarily due to a diagnosis of chronic brain injury following demonstration of significant improvement over a period of six months while receiving rehabilitative services based on approval by NMAP.

12-014.01B1a Criteria for Care: The client must:

1. Require physician services that exceed those described in 471 NAC 12-007.09;
2. Have needs that exceed the nursing facility level of care (that is, needs that cannot be met at a lower level of care such as a traditional nursing facility, assisted living, or a private home), as evidenced by:
   a. Complex medical needs as well as extended training or rehabilitative needs that together exceed the criteria for nursing facility level of care;
   b. Combinations of extended training or rehabilitative needs that together exceed the criteria for nursing facility level of care;
   c. Extended training or rehabilitation needs that require multidisciplinary care including but not limited to those provided by a psychologist, physician, nurse, occupational therapist, physical therapist, speech and language pathologist, cognitive specialist, rehabilitation trainer, etc.; or
   d. Complex combinations of needs from various domains such as behavior, cognitive, medical, emotional and physical.
3. Be capable of participating in an extended training or rehabilitation program evidenced by:
   a. Ability to tolerate a full rehabilitation schedule daily;
   b. Being medically stable and free from complicating acute major medical conditions that would prohibit participation in an extended rehabilitation program;
   c. Possessing the cognitive ability to communicate some basic needs, either verbally or non-verbally;
   d. Being able to respond to simple requests with reasonable consistency, not be a danger to themselves or others, but may be confused, inappropriate, engage in non-purposeful behavior in the absence of external structure, exhibit mild agitation, or have severe attention, initiation, and/or memory impairment (minimum Level IV on the Rancho Los Amigos Coma Scale; and
   e. Being absent of addictive habits and/or behaviors that would inhibit successful participation in the training or rehabilitation program;
4. Have potential to benefit from an extended training or rehabilitation program resulting in reduced care needs, increased independence, and a reasonable quality of life as evidenced by:
   a. Possessing a current documented prognosis that indicates that s/he has the potential to successfully complete an extended training or rehabilitation program;
   b. Possessing the ability to learn compensatory strategies for, or to acquire skills of daily living in areas including, but not limited to transportation, money management, aide management, self medication, social skills, or other self cares which may result in requiring residency in a lower level of residential care; and
   c. Documentation supporting that s/he is making continuous progress in an extended training or rehabilitation program including transitional training for successful discharge or transfer.
12-014.01B2 Criteria for Care of Clients Requiring Long Term Care Services for Brain Injury: The client must:

1. Have needs that exceed the nursing facility level of care (that is, needs cannot be met at a lower level of care such as traditional nursing facility, assisted living, or a private home), as evidenced by:
   a. Combinations of medical, care and/or rehabilitative needs that together exceed the criteria for nursing facility level of care;
   b. Care that requires a specially trained, multi-disciplinary team including but not limited to physician, nurse, occupational therapist, physical therapist, speech and language pathologist, psychologist, cognitive specialist, adaptive technologist, etc.;
   c. Complex care needs occurring in combinations from various domains such as behavior, cognitive, medical, emotional, and physical that must be addressed simultaneously; or
   d. Undetermined potential to benefit from extended training and rehabilitation program;
2. Be capable of participating in clinical program as evidenced by:
   a. Being non-aggressive and non-agitated;
   b. Being absent of addictive habits and/or behaviors that would inhibit participation in clinical program;
3. Have potential to benefit from clinical program as evidenced by:
   a. Being cognitively aware of surroundings and/or events;
   b. Being able to tolerate open and stimulating environment;
   c. Being able to establish/tolerate routines;
   d. Being able to communicate verbally or non-verbally basic needs; and
   e. Requiring moderate to extensive assistance to preserve acquired skills.

12-014.01C Other Special Needs Clients: These clients must require complex medical/rehabilitative care in combinations that exceed the requirements of the nursing facility level of care. These clients may also use excessive amounts of supplies, equipment, and/or therapies. The client must meet the criteria for one of the two following categories:

12-014.01C1 Criteria for Care of Clients with Rehabilitative Special Needs: The client must -

1. Be medically stable and require physician services two - three times per week;
2. Require multi-disciplinary care (for example, physician, nursing, psychology, respiratory therapy, occupational therapy, physical therapy, speech therapy, pharmacy, spiritual care, or specialty disciplines);
3. Require care in multiple body organ systems;
4. Require a complicated medical/treatment regimen, requiring observation and intervention by specially trained professionals, such as:
   a. Multiple stage 2, or at least one stage 3 or stage 4 decubiti with other complex needs;
   b. Multiple complex intravenous fluids, or nutrition with other complex needs;
   c. Tracheostomy within the past 30 day with other complex care needs;
   d. Intermittent ventilator use (less than ten hours in a 24-hour period) with other complex care needs;
   e. Respiratory therapy treatments/interventions more frequently than every six hours with other complex care needs;
   f. Initiation of Continuous Abdominal Peritoneal Dialysis (CAPD) or established CAPD requiring five or more exchanges per day with other complex care needs; or
   g. In room hemodialysis as required by a physician with other complex care needs;

5. Require extensive use of supplies and/or equipment;

6. Have professional documentation supporting that s/he is making continuous progress in the rehabilitation program beyond maintenance goals; and

7. Have care needs that cannot be met at a lesser level of care (for example, skilled nursing facility, nursing facility, assisted living, or private home).

12-014.01C2 Criteria for Care of Pediatric Clients with Special Needs: The client must-

1. Be under age 21;
2. Be medically stable;
3. Require multidisciplinary care (physician, nursing, respiratory therapy, occupational therapy, physical therapy, psychology, or specialty disciplines); and

4. Require a complex medical/treatment regimen requiring observation and intervention by specially trained professionals, such as:
   a. Tracheostomy care/intervention with other complex needs;
   b. Intermittent ventilator use (less than ten hours in a 24-hour period) with other complex needs;
   c. Respiratory therapy treatments/interventions more than every six hours with other complex care needs; or
   d. Multiple complex care needs that in combination exceed care needs usually provided in a nursing facility (for example, variable gastrostomy/nasogastric/jejunostomy feedings with documented aspiration risk; complicated medication regimen requiring titration of meds and/or frequent lab monitoring to determine dosage; multiple skilled nursing services such as intermittent urinary catheterizations, sterile dressing changes, strict intake/output monitoring, intravenous medications, hyperalimentation or other special treatments).
12-014.01D: The revised admission criteria does not apply to clients admitted before the effective date of these regulations.

12-014.01E Exception: Under extenuating circumstances, the Director of Finance and Support may approve an exception to the criteria for care of long term care clients with special needs based on recommendations of HHSS staff.

12-014.02 Facility Qualifications: To be approved as a provider of services for LTC clients with special needs, a Nebraska facility providing services to special needs clients must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure as a hospital or a nursing facility and be certified to participate in the Nebraska Medical Assistance Program (42 CFR 483, Subpart B). Out-of-state facilities must meet licensure and certification requirements of that state’s survey agency. Out-of-state placement of clients will only be considered when their special needs services are not available within the State of Nebraska (see 471 NAC 12002.02G).

The facility must demonstrate the capacity/capability to provide highly skilled multi-disciplinary care. The facility must ensure that its professional nursing staff have received appropriate training and have experience in the area of care pertinent to the individual client's special needs (such as ventilator dependent). The facility must have the ability to provide the necessary professional services as the client requires (such as respiratory care available 24 hours per day, seven days a week).

The facility must –

1. Demonstrate the capability to provide highly skilled multidisciplinary care;
2. Ensure that its staff have received appropriate training and are competent to care for the identified special needs population that is being served (for example, ventilator dependent, brain injury, complex medical/rehabilitation, complex medical pediatrics);
3. Be able to provide the necessary professional services that the special needs clients require (for example, respiratory therapy 24 hours a day, 7 days a week);
4. Have the physical plant adaptations necessary to meet the client’s special needs (for example, emergency electrical back-up systems);
5. Establish admission criteria and discharge plans specific to each special needs population being served;
6. Have a separate and distinct unit for the special needs program;
7. Establish written special program criteria with policy and procedures to meet the needs of an identified special needs group as defined in 471 NAC 12-014.01;
8. Have written policies specific to the special needs unit regarding:
   a. Emergency resuscitation;
   b. Fire and natural disaster procedures;
   c. Emergency electrical back-up systems;
   d. Equipment failure (e.g.: ventilator malfunction);
   e. Routine and emergency laboratory and/or radiology services; and
   f. Emergency transportation.
9. Maintain the following documentation for special needs clients:
   a. A comprehensive multidisciplinary and individualized assessment of the client’s needs before admission. The client’s needs dictate which disciplines are involved with the assessment process. The assessment must include written identification of the client’s needs that qualify the client for the special program as defined in 471 NAC 12-014.01. The initial assessment and the team’s review and decisions for care must be retained in the client’s permanent record. (see 471 NAC 12-014.03A);
   b. A copy of the admission “MDS 2.0 Basic Assessment Tracking Form” (Minimum Data Set), and Form DPI-OBRA1, “Identification Screen”. These are to be maintained as part of the client’s permanent record;
   c. A minimum of daily documentation or assessment and/or intervention by a Registered Nurse or other professional staff as dictated by the client’s needs (e.g., Respiratory Therapy, Occupational or Physical therapy);
   d. A record of physician’s visits; and
   e. A record of interdisciplinary team meetings to evaluate the client’s response and success toward achieving the identified program goals and the team’s revisions/additions/deletions to the established program plan (see 471 NAC 12-014.03D);

10. Maintain financial records in accordance with 471 NAC 12-011 and 12-012; and

11. Provide support services necessary to meet the care needs of each individual client and these must be provided under existing contracts or by facility staff as required by Medicare/Medicaid (42 CFR 483, Subpart B) for nursing facility certification (for example, respiratory, speech, physical or occupational therapies, psychiatric or social services).

12-014.03 Approval Process: NMAP pays for a special need nursing facility service as defined in 471 NAC 12-014 when prior authorized by the designated program specialist in the Central Office. Each admission shall be individually prior authorized.

12-014.03A Prior to Admission: A written comprehensive and individualized assessment completed by the facility must be sent to the Central Office. The assessment and accompanying documentation must address how the client meets the criteria for special needs care as defined in 471 NAC 12-014.01. It is the facility’s responsibility to assess, gather and obtain this information and submit it to the Central Office for prior authorization and before admission.

Initial approval/denial will be given after Medicaid staff reviews the submitted information. It is the facility’s responsibility to obtain and provide any missing or additional information requested by the Central Office. The initial approval will be delayed until all information is received by the Central Office staff. The Pre-Admission Screening Level I Evaluation (see 471 NAC 12-004.04) and Level II Evaluation, when applicable (see 471 NAC 12-004.08), must be completed before admission and the Level II findings/reports must accompany the packet of information sent to the Central Office for funding authorization.

12-014.03A1 Facilities serving the needs of individuals who are ventilator-dependent and other special needs clients (see 471 NAC 12-014.01A and 12-014.01C) must include the individualized admission assessment completed by the facility and other documentation which must include but is not limited to:
1. Current medical information that documents the client’s current care needs;
2. Historical information that impacts the client’s care needs;
3. Discharge summary(ies) of any facility stay(s) within the past 6 months;
4. Current physical/cognitive/behavioral status;
5. Justification for special needs level of care; and
6. Identification of major areas of preliminary care planning (an estimate of services needed to reach the proposed goals).

12-014.03A2 Facilities serving the needs of clients with brain injuries (see 471 NAC 12-014.01B) shall submit the individualized admission assessment completed by the facility and the following documentation which must include but is not limited to:

1. Current medical information that documents the client’s current care needs, including a letter from the client’s primary care physician indicating the potential for successful rehabilitation;
2. Historical information that impacts the client’s care needs;
3. Discharge summaries of any facility stay(s) within the past year;
4. All discharge/service summaries of any rehabilitative (inpatient and outpatient) services received since the qualifying injury;
5. An Individualized Educational Plan (IEP) of any client under age 21 if one exists;
6. An Individual Program Plan and discharge statement/meeting for any client receiving or who has received services from the Developmental Disabilities System since the qualifying injury;
7. The written plan from Vocational Rehabilitative services if the client is receiving or has received since the qualifying injury;
8. Current physical/cognitive/behavior status; and
9. Identification of major areas of preliminary care planning (an estimate of services needed to reach the proposed goals).

12-014.03B Initial Approval: Based on the pre-admission assessment, initial approval/denial will be given by the Central Office staff for a 90-day admission, for assessment and development of a special needs plan of care. During this 90-day period, the individual will be receiving special needs care for the purposes of determining the potential for benefit from longer-term participation in the special needs program. At the end of 30 days, the Central Office will be provided a special needs formal plan of care, developed by the full interdisciplinary team. By the end of the 60th day, a report will be provided to the Central Office establishing demonstrated potential to benefit from the additional special needs programming, and estimating the time needed to complete the special needs plan of care, or recommendations to a lesser level of care.
12-014.03B1 In-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined facility staff shall (see 471 NAC 12-007)-

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.02C (the facility is responsible for verifying the client’s Medicaid eligibility before completion of the MC9-NF) or submit electronically the standard Health Care Services Review Request for Review and Response transaction (ASC X12N 278);
2. Attach a copy of Form DM-5 or physician’s history and physical;
3. Attach a copy of Form DPI-OBRA1; and
4. Submit all information to the Central Office.

Facility staff must make a comprehensive assessment of the resident’s needs within 14 days of admission, using the Minimum Date Set (MDS)2.0, and transmit it electronically to the Central Office in accordance with 42 CFR 483.20.

The HHSS review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time-limited.

12-014.03B2 Out-of-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined, facility staff shall (see 471 NAC 12-007)-

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C (the facility is responsible for verifying the client’s Medicaid eligibility prior to completion of the MC9-NF) or submit electronically the standard Health Care Services Review Request for Review and Response transaction (ASC X12N 278);
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form DPI-OBRA1 (where applicable);
4. Attach a copy of their state-approved MDS; and
5. Submit all information to the Central Office.

The HHSS review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time-limited.
12-014.04 Utilization Review: The Department will review records and programs established for authorized Medicaid client stays in a Special Needs program on a quarterly basis. These reviews can be conducted on-site or by submitting requested documentation to the Department. Upon completion of a review, Department staff may determine that a client no longer meets the criteria as established in 471 NAC 12-014.01. The Department will notify the facility in writing of this finding. Examples of conditions for termination of special needs payment include but are not limited to:

1. The client has medically, physically, or psychologically regressed and cannot participate in the established program documented for at least one month duration;
2. The client refuses to participate in the established program for a documented time of at least one month;
3. The client no longer has documented progress toward established program goals and/or the client’s progress has reached a plateau with no documented progress for at least three months (maintenance goals do not qualify the client to continue the program);
4. The client no longer meets criteria as defined in 471 NAC 12-014 that pertains to his/her specific program needs (for example, ventilator use, complex care needs are resolved, pediatric client turns 22).

12-014.04A Comprehensive Plan of Care: The facility must submit copies of the initial comprehensive plan of care and subsequent interdisciplinary team meetings (see 471 NAC 12-014.02, item 9e) that document the client's progress/lack of progress toward the client’s established program outcomes/goals to the Medicaid Central Office quarterly.

12-014.04B: NMAP will require monthly reviews for extended brain injury rehabilitation stays beyond two years.

12-014.04C Right to Contest a Decision: See 471 NAC 2-003.01.

12-014.05 Payment for Services for Long Term Care Clients with Special Needs: Payment for services to all special needs clients must be prior authorized by Department staff in the Central Office.

12-014.05A Nebraska Facilities: To establish a Nebraska facility’s payment rate for care of special needs clients:

1. The facility must submit Form FA-66, "Long Term Care Cost Report," to the Department for each fiscal year ending June 30. Medicare cost reporting forms may be substituted when Form FA-66 is not otherwise required to be submitted. Form FA-66 must be completed in accordance with 471 NAC 12-012, Completion of Form FA-66, "Long Term Care Cost Report," and 471 NAC 12-011 ff., Rates for Nursing Facility Services, as applicable. Medicare cost reports must be completed in accordance with Medicare’s Provider Reimbursement Manual (HIM-15). If the facility provides both nursing facility services and special needs services, direct accounting and/or cost allocations necessary to distribute costs between the nursing facility and the special needs unit must be approved by the Department of Health and Human Services, Long Term Care Audit Unit.
2. The Department shall compute the allowable cost per day from the most recent State fiscal year Form FA-66 or the most recent Medicare cost report, as applicable, which will be the basis from which a prospective rate is negotiated. Payment for fixed costs is limited to the lower of the individual facility’s fixed cost per diem or a maximum per diem of $54.00 excluding personal property and real estate taxes. Negotiations may include, but are not limited to, discussion of appropriate inflation/deflation expectations for the rate period and significant increases/decreases in the cost of providing services that are not reflected in the applicable cost report. The cost of services generally included in the allowable per diem include, but are not limited to:

   a. Room and board;
   b. Preadmission and admission assessments;
   c. All direct and indirect nursing services;
   d. All nursing supplies, to include trach tube and related trach care supplies, catheters, etc.;
   e. All routine equipment, to include suction machine, IV poles, etc.;
   f. Oxygen and related supplies;
   g. Psychosocial services;
   h. Therapeutic recreational services;
   j. Administrative costs;
   k. Plant operations;
   l. Laundry and linen supplies;
   m. Dietary services, to include tube feeding supplies and pumps;
   n. Housekeeping; and
   o. Medical records.

Services not commonly included in the per diem (unless specifically provided via the facility’s contract) include, but are not limited to:

   a. Speech therapy;
   b. Occupational therapy;
   c. Physical therapy;
   d. Pharmacy;
   e. Audiological services;
   f. Laboratory services;
   g. X-ray services;
   h. Physician services; and
   j. Dental services;

These services are reimbursed under the Department’s established guidelines. Costs of services and items which are covered under Medicare Part B for Medicare-eligible clients must be identified as an unallowable cost.

3. If the facility has no prior cost experience in providing special needs services, the facility must submit a budget for the provision of the intended service. The Department must concur that the budgeted cost per day meets a reasonable expectation of the cost of providing said service, taking into account the cost per day of similar facilities providing similar services. Budgets will be used until the facility has at least six months of actual cost experience.
4. An incentive factor calculated at eight per cent of allowable costs is added to the allowable costs of proprietary facilities. An incentive factor calculated at four percent of allowable costs is added to the allowable costs of other than propriety facilities.

5. After a rate is agreed upon, the Department and the provider must enter into a contract. The contract, written by the Department, must include:
   a. The rate and its applicable dates;
   b. A description of the criteria for care;
   c. A full description of the services to be provided under the established per diem as well as any services that are not provided under the per diem and are billed separately; and
   d. Other applicable requirements that are necessary to be included in all Department contracts.

6. In lieu of the rate establishment procedure described in this section and under mutual agreement of both the provider and the Department, a multi-year contractual arrangement may be entered into by the parties. Reimbursement must reflect the facility’s actual reasonable cost of providing services to special needs clients and must be updated annually using an appropriate inflation adjustment.

12-014.05B Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at a rate established by that state’s Medicaid program at the time of the establishment of the Nebraska Medicaid provider agreement. The payment is not subject to any type of adjustment.

12-014.05C Payment for Bedhold: The Level 105 rate, as defined in 471 NAC 12-011.08F, will be used as a basis for payment of hospitalization and/or therapeutic leave from which a prospective rate is negotiated.

12-014.06: The requirements of 471 NAC 12 apply to services provided under 471 NAC 12-014 unless otherwise specified in 471 NAC 12-014.

12-014.07 In-Home Services for Certain Disabled Children: This section applies to children age 18 or younger with severe disabilities living in their parents' home, also referred to as the "Katie Beckett" program (also see 469 NAC 2-010.01F).

Services for special needs children are a skilled level of care provided by a certified Home Health agency, licensed RN's or LPN's. These providers must have necessary training/experience in the care of ventilator-dependant, pulmonary, and/or other special needs clients.
This level of care is highly skilled, provided by professionals in amounts not normally available in a skilled nursing facility, but available in the hospital. Lack of these services would normally result in continued hospitalization/institutionalization of these children. The cost of in-home services must be less than the cost of hospitalization.

The child must meet one of the following definitions to qualify for the Katie Beckett program:

1. Ventilator-Dependent Clients: These clients are ventilator-dependent and require intensive medical services/continual observation on an on-going basis.
2. Pulmonary Clients: These clients must require complex respiratory/medical care, e.g., tracheostomy, intensive IPPB treatments, etc., in combinations which exceed the needs of the skilled nursing client. These clients may also use excessive amounts of supplies and equipment.
3. Other Special Needs Clients: The clients must require complex medical/rehabilitative care in combinations, which exceed the requirements of the skilled nursing client. These clients may also use excessive amounts of supplies, equipment, and/or therapies.

Central Office approval for this level of care is required.
12-014.08 INTERMEDIATE SPECIALIZED SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

12-014.08A Introduction: The Nebraska Medical Assistance Program (NMAP) covers "intermediate specialized services (ISS) for persons with serious mental illness". ISS are covered for those individuals who have been identified by the Level II Preadmission Screening Process (PASP) evaluation and through the ISS evaluation process as needing services to maintain or improve their behavioral or functional levels above and beyond services that nursing facilities normally provide, but who do not require the continuous and aggressive implementation of an individualized plan of care, as "specialized services" is defined by PASP regulations in 471 NAC 12-004. These individuals need more support than nursing facilities would normally provide, but not at a "specialized services" level.

12-014.08B The requirements of 471 NAC 12 apply to ISS provided under 471 NAC 12-014.08 thru 12-014.08M unless otherwise specified.

12-014.08C Definition: Intermediate Specialized Services (ISS) for Individuals with Serious Mental Illness means services necessary to prevent avoidable physical and mental deterioration and to assist clients in obtaining or maintaining their highest practicable level of functional and psycho-social well being. Services are characterized by:

1. The client’s regular participation, in accordance with his/her comprehensive care plan, in professionally developed and supervised activities, experiences, and therapies;
2. Activities, experiences, and therapies that reduce the client’s psychiatric and behavioral symptoms, improve the level of independent functioning, and achieve a functional level that permits reduction in the need for intensive mental health services.

12-014.08D Program Components: ISS is designed to:

1. Provide and develop the necessary services and supports to enable clients to reside successfully in a nursing facility without the need of more intensive specialized services;
2. Maximize the client's participation in community activity opportunities, and improve or maintain daily living skills and quality of life;
3. Facilitate communication and coordination between any providers that serve the same client;
4. Decrease the frequency and duration of hospitalization and inpatient mental health (MH) services;

5. Provide client advocacy, ensure continuity of care, support clients in time of crisis, provide and procure skill training, ensure the acquisition of necessary resources, and assist the client in achieving social integration;

6. Expand the individual’s comprehensive care plan to assure that it includes interventions to address: community living skills, daily living skills, interpersonal skills, psychiatric emergency and relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related areas necessary for successful living in the community;

7. Provide the individualized support and rehabilitative interventions as identified through the comprehensive care planning process to address client needs in the areas of: community living skills, daily living skills, interpersonal skills, psychiatric emergency and relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related services necessary for successful living in the community;

8. Monitor client progress in the services being received and facilitate revision to the comprehensive care plan as needed;

9. Provide therapeutic support and intervention to the client in time of crisis and, if hospitalization is necessary, facilitate, in cooperation with the inpatient treatment provider, the client’s transition back into the client’s place of residence upon discharge;

10. Establish hours of service delivery that ensure program staff are accessible and responsive to the needs of the client, including scheduled services that include evening and weekend hours; and

11. Provide or otherwise demonstrate that each client has on call access to a mental health provider on a 24 hour, 7 days per week basis.

12-014.08E Criteria for ISS: For ISS, the client must have been evaluated through the PASP process and the ISS evaluation process, and been determined to not need specialized services based on the outcomes of the Level II evaluation and the ISS Evaluation Process. The ISS Evaluation Process must include, but is not limited to, evaluation by a team which must consider an individual’s long term residence in a mental health facility, higher levels of aggression, and higher levels of medical need. The client must be currently diagnosed with a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of DSM or ICD-9-CM equivalent (and subsequent revisions) except DSM “V” codes, substance use disorders, developmental disorders, and dementia which are excluded, unless they co-occur with another diagnosable serious mental illness.
12-014.08F Comprehensive Care Plan Development: The Department or its designee will refer clients authorized for ISS to the most appropriate provider(s), consistent with client choice. The ISS provider must work with the client to complete a comprehensive care plan that includes:

1. An assessment of the client's strengths and needs in that service domain according to the requirements of the Level II evaluation found at 471 NAC 12-004.09 and 12-004.13C and the ISS evaluation process; and
2. The Resident Assessment in accordance with 471 NAC 12-007.06 and 12-007.07.

12-014.08G Movement Between Specialized Services, ISS, and Regular Nursing Facility Services: Individuals' needs change over time and level of service intensity must change to appropriately meet those needs. Nursing facility staff and other service providers must identify changes in level of need as they occur. Such changes would include a decline in psychiatric stability that requires specialized services or marked decrease in the need for ISS. See 471 NAC 12-004.02.

12-014.08G1 Increase in Service Needs: Nursing facility staff must request review by the consulting psychiatrist when ISS are not sufficient to meet a client’s needs (i.e., escalation in behavioral challenges, marked decreases in functional level, decreases in mental stability that might require inpatient stays). Based on the findings of the consulting psychiatrist, the client may be moved to an inpatient facility for receipt of specialized services.

12-014.08G1a Returning from Receiving Specialized Services for Mental Illness: For ISS clients, this process must follow procedures at 471 NAC 12-004.09A and 12-014.08E.

12-014.08G2 Decrease in Service Needs: When the need for ISS decreases, regular services that the nursing facility would normally provide may be sufficient. In addition to the normal discharge planning process under 471 NAC 12-007.19, ISS facility staff must request review by the ISS evaluation team. With the team's approval, the client may be transferred to regular nursing facility services.

12-014.08H Transfers: For ISS clients, transfers between nursing facilities will not require a Level I or Level II PASARRP evaluation. See 471 NAC 12-004.04. A Tracking Form must be completed and faxed to the HHSS PASP contractor for clients with a PASP determination.
12-014.08I Standards for Provider Participation: ISS providers may be any nursing facility certified to participate in Medicaid and Medicare. If the ISS provider subcontracts with service providers, they must be Medicaid enrolled providers. All providers of ISS must be approved and meet all applicable requirements under Title 471, Chapter 2-000, Provider Participation and other applicable sections of the NAC. However, for the purposes of effectiveness and efficiency in delivering these services, the Department approves ISS providers through a proposal process, and certifies all or part of a facility to provide ISS services. The Department will announce, through public notice, when it will entertain facility proposals. These announcements will detail to potential ISS providers the primary locations, number of beds, architectural standards, staffing requirements, and any other information to assist facilities with their proposals.

12-014.08J Staff Requirements: The facility must maintain a sufficient number of staff with the required training, competencies, and skills necessary to meet the client’s needs. Training must be approved by the Department and specific to the delivery of ISS and related mental health services. At a minimum, the ISS facility must have a consulting psychiatrist. It must develop and implement a comprehensive care plan for each ISS client, ensure necessary monitoring and evaluation and must modify the care plan when appropriate. Staff must have the skills to care for the clients, know how to respond to emergency and crisis situations and fully understand client rights. The facility must provide care and treatment to clients in a safe and timely manner and maintain a safe and secure environment for all residents.

12-014.08J1 Staff Credentialing: The facility must ensure that:

1. Any staff person providing a service for which a license, certification, registration, or credential is required holds the license, certification, registration, or credential in accordance with applicable state laws;
2. The staff have the appropriate license, certification, registration, or credential before providing a service to clients including training specific to the delivery of ISS and related mental health services; and
3. It maintains evidence of the staff having appropriate license, certification, registration, or credential.

12-014.08J2 Initial Orientation: The facility must provide staff with orientation before the staff person having direct responsibility for care and treatment of clients receiving ISS provides services to clients. The training must include:

1. Client rights;
2. Job responsibilities relating to care and treatment programs and client interactions;
3. Emergency procedures including information regarding availability and notification;
4. Information on any physical and mental special needs of the clients of the facility;
5. Information on abuse, neglect, and misappropriation of money or property of a client and the reporting procedures;
6. De-escalation techniques;
7. Crisis intervention strategies;
8. Behavior management planning and techniques;
9. The role of medication in psychiatric treatment;
10. CPR and medical first aid; and
11. Strength-based services and the recovery model.

The facility must maintain documentation of staff initial orientation and training.

12-014.08J3 Ongoing Training: The facility must provide each staff person ongoing training in topics appropriate to the staff person’s job duties, including meeting the needs, preferences, and protecting the rights of the clients in the facility.

12-014.08K Client Rights: The facility must ensure that clients rights are ensured in accordance with 42 CFR 483.10 and 175 NAC 12-006.05.

12-014.08L Utilization Review: The Department or its designee will provide utilization review for ISS. This includes assessing the appropriateness of the intensity of services and providing ongoing utilization review of the client's progress in relation to the comprehensive care plan. At least annually, the Department or its designee will reassess clients receiving ISS, and will review and approve new service recommendations and continued eligibility for ISS.

12-014.08M Payment: The Department pays for ISS services as specified in 471 NAC 12-014.05.
12-015 MEDICAID PAYMENT WHEN A MEDICAID CLIENT RESIDING IN A NURSING FACILITY OR ICF/MR ELECTS THE MEDICARE OR MEDICAID HOSPICE BENEFIT

12-015.01 Standards for Participation: To participate in the Nebraska Medical Assistance Program (Medicaid), a hospice shall be a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified for participation in Medicare as a hospice.

12-015.01A Provider Enrollment: To complete the provider enrollment process for adult clients, the hospice shall meet the following conditions:

1. The hospice shall have a signed, written, non-resident-specific contract with each certified nursing facility or ICF/MR; and
2. The hospice shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," for each contracted nursing facility or ICF/MR and submit the form with the contract attached to the Nebraska Department of Health and Human Services.

12-015.02 Covered Services: Nebraska Medicaid shall pay the hospice for the client's board and room in the facility (NF or ICF/MR) when the following conditions are met:

1. The hospice and the facility shall have a written agreement under which the hospice is responsible for the professional management of the client's hospice care;
2. The client shall be eligible for Medicaid benefits;
3. The client shall have elected to receive the Medicare or Medicaid hospice benefit;
4. The client shall reside in a Medicaid-certified bed in the facility (NF or ICF/MR);
5. The client's medical needs must meet the Medicaid criteria and be approved for nursing facility (NF) or intermediate care for the mentally retarded (ICF/MR) level of care; and
6. The client is an adult.

Nebraska Medicaid shall not pay the hospice for the client's board and room expense in the facility (NF or ICF/MR) if the client is a child.
12-015.03 Definition of Hospice: Hospice or hospice services shall meet the definition in 471 NAC 36-002.

12-015.04 Prior Authorization Process: The following steps shall be completed before Medicaid authorizes payment to the hospice:

1. The Preadmission Screening Process (PASARR) shall be completed before the client is admitted to the facility (see 471 NAC 12-004);

2. The hospice shall obtain prior authorization for nursing facility payment by paper or electronically. If obtained by paper, an MC-9NF shall be submitted with paper attachments according to #4 for a new admission to an NF who has chosen the Hospice benefit, or according to #5 for Medicaid covered residents in an NF converting to Hospice. If electronically, the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 276) shall be submitted with paper attachments according to #4 for a new admission to a NF who has chosen the Hospice benefit, or according to #5 for Medicaid covered residents in a NF converting to Hospice. (See Standard Electronic Transmissions at 471-000-50);

3. The hospice contracted nursing facility shall complete and electronically transmit Form MDS 2.0, “Minimum Data Set” to Central Office according to CMS requirements. For ICF/MR level of care (see 471 NAC 31-000);

4. The hospice shall forward the following to HHS Central Office –
   a. Form DPI-OBRA1 (Identification Screen);
   b. The completed Form MC-9NF (in its entirety);
   c. A copy of the DM-5 or History & Physical;
   d. The Hospice plan of care;
   e. A list of Hospice covered medications and pharmacy notification; and
   f. A list of Hospice covered medical appliances, supplies, and therapies and provider notification.

5. If the client is Medicaid eligible and already residing in the nursing facility, the hospice shall complete and submit to Central Office –
   a. Form MC-9NF;
   b. Hospice plan of care and certification;
   c. List of hospice covered medications and pharmacy notification; and
   d. List of hospice covered medical appliances, supplies, and therapies and provider notification.

12-015.04A Required Assessments: The hospice contracted nursing facility shall electronically submit to the Department –

1. Quarterly assessments of each client on MDS 3.0 Quarterly Review; and
2. Form MDS 3.0 annually or whenever any significant change occurs.
12-015.05 Payment to the Hospice: Medicaid’s payment to the hospice shall be 95 percent of the case mix per diem rate established by the Department for the nursing facility in which the client resides, based on the MDS 3.0 for each individual.

The hospice shall make payment to the nursing facility for the client's board and room according to the contract between the facility and the hospice.

The Department shall not pay the nursing facility or ICF/MR for any client covered under 471 NAC 12-015 as long as the client elects to receive the Medicare Hospice benefit.

The provider shall not bill Medicaid or the Department for any provider service that is included in the Medicare hospice benefit, i.e., drugs, physician's services, equipment, etc., related to the terminal illness, nor for services covered under the Medicaid nursing facility or ICF/MR per diem.

12-015.05A Billing: Providers shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).
CHAPTER 13-000  NURSING SERVICES

13-001 Standards for Participation: Providers of private-duty nursing services must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure as a home health agency or individual RN/LPN or the appropriate licensing agency of the state in which s/he practices. To participate in the Nebraska Medical Assistance Program (NMAP), the provider shall complete and sign Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90), and submit the completed form to HHS for approval and enrollment as a provider.

13-001.01 Standard of Practice: RNs and LPNs must practice within their scope of practice as defined in Nebraska Administrative Code Title 172, Chapters 97, 99, 101, and 102.

13-002 Covered Services: NMAP covers RN/LPN services when ordered by the client's physician based on medical necessity. Skilled nursing services are those services provided by a registered nurse or a licensed practical nurse which s/he is licensed to perform. Private-duty nursing may be provided in the client's home or current living arrangement.

13-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

13-002.01A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

13-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. In addition, services provided by a RN/LPN require referral from the client's primary care physician (PCP) and authorization by the NHC PCCM plan. Providers shall contact the PCP before providing services. All services provided to clients enrolled in NHC PCCM plans are billed to the Department.
13-002.02 Medical Necessity: All skilled nursing services must be -

1. Necessary to a continuing medical treatment plan;
2. Prescribed by a licensed physician; and
3. Recertified by the licensed physician at least every 60 days.

13-002.03 Definition of Nursing Service: Nursing services are services provided to a client in the client’s place of residence. The residence does not include a hospital, skilled nursing facility, or nursing facility.

To be eligible for skilled nursing services, the attending physician shall certify that -

1. Based on the client’s medical condition, Home Health services are medically necessary and appropriate services to be provided in the home;
2. Extended home nursing services are medically necessary;
3. That observation/teaching in the home environment is an integral and necessary part of the plan; or
4. Client's care needs require skilled nursing services to maintain/improve their health status.

A client who requires and is authorized to receive extended-hour home health nursing services in the home setting may use his/her approved hours outside of the home during those hours when his/her normal life activities take him/her out of the home, i.e., attend school, therapeutic activities, etc. The Department will not authorize any additional hours of nursing service beyond what would normally be authorized. If a client requests/requires nursing services to attend school or other activities outside the home, but does not need nursing services in the home during those hours, nursing services cannot be authorized.

13-002.04 Guidelines for Coverage:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>NMAP COVERS:</th>
<th>NMAP DOES NOT COVER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medications</td>
<td>Intravenous or intramuscular injections and intravenous feeding. Oral medications covered only where the complexity of the medical condition (physical/psychological) and the number of drugs require a licensed nurse to monitor, detect, and evaluate side effects and/or compliance (this must be well-documented).</td>
<td>Injections that can be self-administered (insulin); drugs not considered an effective treatment for condition given; a medical reason does not exist for providing drug by injection rather than by mouth.</td>
</tr>
<tr>
<td>SERVICE</td>
<td>NMAP COVERS:</td>
<td>NMAP DOES NOT COVER:</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>2. Vitamin B-12 Injections</td>
<td>For physician ordered treatment of pernicious anemia and other macrocytic anemias, and neuropathies associated with pernicious anemia.</td>
<td>For other conditions which are not specifically covered.</td>
</tr>
<tr>
<td>3. Decubitus and Skin Disorders</td>
<td>When specific physician orders indicate skilled care -- requiring prescribed medications and treatment. Usually Stage III (deep without necrotic tissue) and Stage IV (deep with necrotic tissue). Infected decubiti included when treatment is specifically ordered by the physician.</td>
<td>Preventative and palliative measures, decubiti are minor usually Stage I (reddened area or inflammation) or Stage II (superficial skin break and redness surrounding).</td>
</tr>
<tr>
<td>4. Colostomy, Ileostomy, Gastrostomy</td>
<td>During immediate postoperative time when maintenance care and control by the patient or family is being established; includes initial teaching.</td>
<td>General maintenance care.</td>
</tr>
<tr>
<td>5. Bowel and Bladder Training</td>
<td>Teaching of skills and facts necessary to adhere to a specific formal regime.</td>
<td></td>
</tr>
<tr>
<td>6. Urethral Catheters and Sterile Irrigations</td>
<td>Insertions and changes when active urological problems are present and/or client is unable to do physician-ordered irrigations.</td>
<td>Routine catheter maintenance care.</td>
</tr>
<tr>
<td>7. Observation and Evaluation</td>
<td>Observation and evaluation requiring the furnishing of a skilled service for an unstable condition. The client has had a recent acute episode (past 30-60 days) or there is a well-documented history of noncompliance without nursing intervention. Significant high probability that complications would arise (within 30 to 60 days) without the skilled supervision of the treatment program on an intermittent basis.</td>
<td>General needs. Absence of any clear indication that the condition is unstable.</td>
</tr>
<tr>
<td>SERVICE</td>
<td>NMAP COVERS:</td>
<td>NMAP DOES NOT COVER:</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>8. Teaching and Training Activities</td>
<td>Teaching or training requiring the skills or knowledge of a nurse. Injections, irrigating of a catheter, care of ostomy, administration of medical gases, respiratory treatment, preparation and following a therapeutic diet, application of prescription medications and aseptic techniques, bladder training, bowel training (only when bowel incontinency exists), use of adaptive devices &amp; special techniques when loss of function has occurred, care of bed-bound patient, performance of body transfer activities; requires specific documentation.</td>
<td>Visits made solely to remind or emphasize the need to follow instructions; when services are duplicated.</td>
</tr>
<tr>
<td>9. Enemas/Removal of Impactions</td>
<td>When skills of a nurse are required; if complexity is established because of the condition of the patient.</td>
<td></td>
</tr>
<tr>
<td>10. Dressings</td>
<td>Aseptic technique and prescription medications used.</td>
<td>Non-infected closed postoperative wound or chronic controlled conditions (stasis ulcers).</td>
</tr>
<tr>
<td>11. Casts</td>
<td>If orders reflect other than routine care.</td>
<td>General supportive care.</td>
</tr>
<tr>
<td>12. Diabetic (Blind or Disabled)</td>
<td>Visits to prefill insulin syringes. Blood sugar testing, foot care.</td>
<td></td>
</tr>
<tr>
<td>13. Teaching &amp; Training (Postpartum)</td>
<td>Teaching and training require the skills or knowledge of a nurse. Limited to two visits, unless unusual situation is well documented.</td>
<td>Visits made solely to remind or emphasize the need to follow instructions.</td>
</tr>
<tr>
<td>14. Draw or Collect Laboratory Specimens</td>
<td>Covered only if based on the client's medical condition. Home health services are medically necessary and appropriate services to be provided in the home.</td>
<td>These services for nursing home clients.</td>
</tr>
</tbody>
</table>
13-002.05 Extended-Home Nursing Services: Provision of extended-home nursing services (RN or LPN) must be authorized by Central Office staff. These services are authorized for eligible adults or children when -

1. Night hours are necessary so the caregiver/parents may sleep;
2. Day hours to cover work/school for the caregiver/parents; and/or
3. Respite hours to provide relief for caregiver/parents.

Extended-home nursing services are authorized only when the client's care needs must be provided by skilled nursing personnel in the absence of the caregiver/parents. Children must have documented medical needs that cannot be met by the regular child care provider system.

Any change in the client's condition or schedule of the caregiver/parents require a reevaluation of the approved nursing hours.

Written verification of the caregiver/parents' work/school schedule must be submitted initially, annually and anytime there is a change in those hours.

Nursing care hours approved specifically for sleep and/or work/school must be used as authorized, i.e., night hours, are to be used at night, work hours are to be used only when the caregiver/parents are both actually working.

Nursing hours are approved for the client when the caregiver/parent attends education classes working toward a degree. Hours are not covered for any additional degrees beyond an initial college degree.

13-002.05A Nursing Coverage at Night: Caregivers/families may be eligible for night hours if the client requires procedures on an ongoing basis throughout the night hours. Night hours will be authorized only if the monitoring and treatments cannot be accomplished during day and evening hours. The rationale for night hours is to provide caregivers/families with sleep so they can care for the client during the day. The goal must be to develop treatment and sleep patterns so the client can sleep during the night and nursing coverage will not be necessary. The medical necessity for monitoring/treatments during the night hours must be reflected in the physician’s orders and nursing notes.

If a scheduled night shift is cancelled by the provider, the caregiver/family may reschedule those hours with the provider within the next 24 hours. When that is not possible, they may reschedule the hours within the 48 hours following the missed shift.
13-002.05B Respite: Caregivers/families who are allotted respite hours on a weekly or monthly basis can use those hours in any time configuration they determine best to meet their needs within a calendar month. If they would like to "pool" respite hours across two months, prior approval is required.

The number of respite hours approved is based on each individual situation, taking into consideration the client's and caregiver/family's needs.

13-003 Limitations and Requirements for Skilled Nursing Services

13-003.01 Authorization: Payment for all skilled nursing services must be authorized. The eligibility of the client must be verified by the provider. The Division of Medicaid and Long-Term Care or its designee may grant authorization of payment for skilled nursing services.

Providers must send requests for authorization electronically using the standard Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or by submitting Form MS-81 to the Medicaid designee. Requests must include the physician's order and the treatment plan. The treatment plan must include:

1. The client's name, address, case number, and date of birth;
2. The dates of the period covered (not exceeding 60 days);
3. The diagnosis;
4. The type and frequency of services;
5. The equipment and supplies needed;
6. A brief, specific description of the client's needs and services provided; and
7. Any other pertinent documentation which justifies the medical necessity of the services.

If denied, the Department notifies the provider.

13-003.02 Teaching and Training: The Department limits skilled nursing visits for teaching and training on an individual basis. The Department requires specific documentation for teaching and training. The client must have a medical condition which has been diagnosed and treated by a physician. There must be a physician's order for the specific teaching and training.

The Department limits postpartum visits for teaching and training to two visits. The necessity of further visits must be justified and well documented. Court-ordered services and requests from local office staff when Adult/Child Protective Services is involved are covered services when medical necessity is documented.
13-003.03 Second Visit on Same Day: The medical necessity of a second visit on the same date of service must be well documented. Substantiating documentation must be submitted.

13-003.04 Enterostomal Therapy: NMAP recognizes enterostomal therapy visits as a skilled nursing service.

13-003.05 Nursing Services (RN and LPN) for Adults Age 21 and Older: NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older (this includes Nursing Services, 471 NAC 13-000):

1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.

2. Per diem reimbursement for all other in-home nursing service shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level (see 471 NAC 12-013). This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

13-003.06 Extended-Hour Nursing: When providing extended-hour nursing care, the Department will authorize payment to a provider for a maximum of 48-56 hours/week, depending upon the complexity of a client's care. A maximum of 12 hours may be approved in a 24-hour period.

13-004 Non-Covered Services: NMAP does not cover nursing services when the private-duty nurse is an employee of another provider and the services performed are the responsibility of that provider.
13-005  Payment for Nursing Services: The Department pays for approved nursing services at the lower of -

1. The submitted charge; or
2. The maximum allowable fee as established by the Department. See 471-000-513.

13-006  Billing Requirements: RN/LPN providers shall submit electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) or use Form MC-82N, "Private Duty Nurse Claim Form" (see 471-000-59).

13-007  Documentation

13-007.01 Provider Documentation: The private-duty nurse shall maintain records to document services provided and the time worked for which payment is claimed. These records must be readily available upon the Department's request. Records must be retained for six years for audit purposes.

Records must include:

1. Current, signed physician's orders for the care provided;
2. Assessment of the client's health status;
3. Plan of Care;
4. Nurses' notes documenting the care provided; and
5. Time sheets documenting the date and times that care was provided.

The Department does not require that this documentation be done on any particular form. This is the responsibility of the provider.

13-007.02 Client Records: The private-duty nurse shall maintain a medical record in the client's home which includes the Form MS-81, "Certification and Plan of Care For Private-Duty Nursing."

13-007.03 Multiple RN/LPN Providers: When more than one RN/LPN is providing care for a client, the providers and client must determine which RN/LPN will be the coordinator of services. The coordinator will be responsible for completing the Form MS-81, "Certification and Plan of Care For Private-Duty Nursing," obtaining physician orders, obtaining authorization for providing services, and making copies available to the other providers.
CHAPTER 14-000  OCCUPATIONAL THERAPY SERVICES

14-001  Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), the occupational therapist must be licensed by the Nebraska Department of Health and Human Services. If services are provided outside Nebraska, the occupational therapist must be:

1. Registered by the American Occupational Therapy Association; or
2. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association; or
3. Where applicable, licensed by the State.

14-001.01  Licensed Occupational Therapy Assistants: NMAP does not enroll licensed occupational therapy assistants (LOTA) as providers. Services provided by a LOTA are billable to NMAP when all requirements of 172 NAC 114 are met.

If services are provided outside Nebraska, the supervising occupational therapist must submit a photocopy of the occupational therapy assistant license. The supervising occupational therapist will be notified by the Department of Health and Human Services, Division of Medicaid and Long Term Care, if services provided by the occupational therapy assistant are not billable to NMAP.

14-001.02  Provider Agreement: The occupational therapist must complete and sign Form MC-19, “Medical Assistance Provider Agreement,” (see 471-000-90) and submit it to the Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care to be approved for provider enrollment.

14-002  Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

14-002.01  Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider must provide services only under arrangement with the HMO.

14-002.02  Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. The client's primary care physician (PCP) in the PCCM must refer the client for occupational therapy services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.
14-003 Covered Services: NMAP covers occupational therapy services when the following criteria are met:

1. The services are ordered by a licensed physician;
2. The services are medically necessary;
3. The services are of such a level of complexity and sophistication or the condition of the patient is such that only a licensed occupational therapist can safely and effectively perform the service; and
4. The occupational therapy service meets at least one of the conditions listed in 471 NAC 14-003.01 or 14-003.02.

14-003.01 Services for Individuals Age 21 and Older: NMAP covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy and speech therapy) The services must be:

1. An evaluation; or
2. Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time;
3. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

14-003.02 Services for Individuals Age 20 and Younger: NMAP covers occupational therapy services for individuals birth to age 20 when the following criteria are met. The service must be:

1. An evaluation; or
2. Reasonable and medically necessary for the treatment of the client’s illness or injury; or
3. Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time; or
4. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.
14-003.03 Maintenance Therapy: NMAP does not cover maintenance therapy provided by a occupational therapist. The occupational therapist must:

1. Evaluate the client's needs; and
2. Design a maintenance program; and
3. Instruct the client, family members, or nursing facility staff in carrying out the program.

14-003.04 Orthotic Appliances and Devices: NMAP covers orthotic appliances and devices when medically necessary for the client's condition, and when the orthotic appliance or device is applied or used during the therapy session.

14-003.05 Supplies: NMAP will consider payment for certain supplies that are used during the course of treatment and require application by the occupational therapist except those supplies that are considered incident to the procedure provided.

Note: For coverage of orthotic appliances and devices or supplies by a hospital outpatient or emergency room see 471 NAC 10-000, Hospital Services.

14-004 Non-Covered Occupational Therapy Services: NMAP does not cover occupational therapy services in the following situations:

1. Clients Age 21 and Older – therapy sessions in excess of 60 sessions per fiscal year for any combination of physical therapy, occupational therapy, and speech therapy;
2. Therapy for work hardening, or vocational and prevocational assessment and training;
3. Therapy for functional capacity evaluations, educational testing, drivers training, or training in non-essential self-help or recreational activities (e.g. homemaking, cooking, finance), training related to a learning disability or attention disorder, visual perception training, or treatment of psychological conditions;
4. In-service training for nursing facility staff which is not client specific. (These services may be allowed under nursing facility reimbursement as a consulting service.);
5. Rental of equipment; or
6. Take home supplies.
14-005 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of “Treatment Services” in 471 NAC 33-001.04. These services must be prior authorized by the Division of Medicaid and Long-Term Care.

14-006 Payment for Occupational Therapy Services

14-006.01 Payment for Individual Providers: NMAP pays for covered occupational therapy services at the lower of:

1. The provider’s submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Division of Medicaid and Long-Term Care (indicated as "BR" - by report, or "RNE" - rate not established, in the fee schedule).

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-517).

14-006.01A Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; or
4. Adjust the allowable amount when the Division of Medicaid and Long-Term Care determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of the revisions and their effective dates.
14-006.02  Hospitals:  For payment as hospital service, see 471 NAC 10-000, Hospital Services.

14-006.03  Home Health Agencies:  For payment as a home health agency service see 471 NAC 9-000, Home Health Agency Services.

14-007  Billing Requirements

14-007.01  Medicare or Other Insurance Coverage:  If the client is eligible for Medicare or has other insurance which may cover occupational therapy, the provider must bill the Medicare carrier or the insurance company before submitting a claim to the Department.

14-007.02  Medical Necessity Documentation:  The provider must provide the following information when submitting a claim for occupational therapy services:

1. Date of illness/injury onset.
2. Date occupational therapy plan established.
3. Date occupational therapy started.
4. Number of occupational therapy visits from onset.

14-007.03  Utilization Review:  Claims for occupational therapy services are subject to utilization review by the Department to determine medical necessity and appropriateness of the service.

14-007.04  Required Forms and Standard Electronic Transactions:  Depending on the place of service, the provider must use the forms and transactions required by NMAP as follows:

1. If the service is provided at the patient's home or the therapist's office, the provider must claim payment on Form CMS-1500 (see 471-000-61) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The provider must use the appropriate place of service code and CPT or HCPCS codes on the claim;
2. If the service is provided in a hospital, the hospital makes payment to the occupational therapist. The hospital submits claims to NMAP for occupational therapy services provided in the hospital to inpatients and outpatients on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837); and
3. If the service is provided by a home health agency, the agency must claim payment on Form CMS-1450 (see 471-000-57) or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

The provider of the provider's authorized agent must enter the provider's usual and customary charge for each procedure code listed on or in the claim.
Procedure Codes: Individual providers billing on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) must use the American Medical Association’s Current Procedural Terminology (CPT) or HCPCS procedure codes when billing NMAP.

Hospital providers billing on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) must use the appropriate revenue codes when billing NMAP.

Home health agencies billing on Form CMS-1450 or the standard electronic Health Care Claim: Institutional (ASC X12N 837) must use the appropriate procedure codes.
CHAPTER 15 PERSONAL ASSISTANCE SERVICES

15-001 Scope and Authority

15-001.01 Scope: These regulations are established to ensure personal assistance services will support and augment independence, employment, empowerment, dignity, and human potential through provision of flexible, efficient, and needed services to eligible clients. Personal assistance services are intended to supplement the client’s own personal abilities and resources.

15-001.02 Authority: Medicaid personal assistance services are defined in federal regulations at 42 CFR 440.167, and are an optional Medicaid benefit. The Nebraska Medical Assistance Program (NMAP), also known as Medicaid, offers personal assistance services as defined in 471 NAC 1-002, item 17. The Special Services for Children and Adults Division within the Nebraska Department of Health and Human Services has responsibility for administering personal assistance services within the Medicaid Program.

The Nebraska Legislature grants the authority to adopt rules and regulations for this service to the Director of the Department of Health and Human Services Finance and Support in Neb. Rev. Stat. § 68-1021.

15-002 Definitions of Terms: As used in this chapter, unless the context demands otherwise, the following definitions apply:

Activities of Daily Living (ADL) means those self-care activities which must be accomplished by an individual for continued well-being including mobility and transferring, dressing and grooming, bathing and personal hygiene, toileting/bladder care, and eating.

Adult Day Service means a person or any legal entity which provides care and an array of social, medical, or other support services for a period of less than 24 consecutive hours in a community-based program to person who require or request such services due to age or functional impairment.

Caretaker, as defined in Neb. Rev. Stat. § 71-1, 132.30 of the Nurse Practice Act, which explains health maintenance activities, means a person who (1) is directly and personally involved in providing care for a minor child or incompetent adult and (2) is the parent, foster parent, family member, friend, or legal guardian of such minor child or incompetent adult.

Central Office means the Special Services for Children and Adults Division within the Office of Aging and Disability Services in the Nebraska Department of Health and Human Services.
Client means the individual eligible for personal assistance services.

Competent adult, as defined in Neb. Rev. Stat. § 71-1, 132.30 of the Nurse Practice Act, which explains health maintenance activities, means someone who has the capability and capacity to make an informed decision.

Competitive integrated employment means working a minimum of 40 hours per month at minimum wage.

Department means the Nebraska Department of Health and Human Services.

Designee means any entity with whom the Nebraska Department of Health and Human Services Finance and Support has an interagency agreement or contract for administration or management of personal assistance services or for resource development.

Home environment means the client’s primary residence which is not a setting that provides staff support or supervision, or any licensed health care facility, including assisted living facilities and other licensed residential service programs, and nursing facilities.

Licensed residential service program means an assisted living facility, center for the developmentally disabled, group home for the developmentally disabled, mental health center, substance abuse treatment center, and respite care service program. These programs are licensed by the Nebraska Department of Health and Human Services Regulation and Licensure.

Local office means the Nebraska Department of Health and Human Services office in or closest to the client’s and/or provider’s home community in Nebraska.

Personal assistance services means a task which provides the client’s activities of daily living and other activities as listed in 471 NAC 15-003.01.

Provider or Personal assistance service provider means the individual who actually performs the personal assistance service(s) and meets the qualifications cited in 471 NAC 15-006.01.

Social Services Worker means the Nebraska Department of Health and Human Services employee at the local office who is responsible for working with clients to determine eligibility and authorize services.

15-003 Scope of Services

15-003.01 Covered Services: Personal assistance services include a defined range of human assistance, chosen and directed by the individual or designee or at the direction of a parent or guardian for a minor child or legally incompetent adult. Personal assistance services are provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability.
Personal assistance services are based on individual needs and criteria that must be determined in a written assessment. Services authorized on a written service plan must relate directly to the needs identified in the assessment. (See 471 NAC 15-004.03C) Prior authorization must be obtained from Central Office for services authorized in excess of 40 hours per week. These services include:

1. Basic personal hygiene – providing or assisting with bathing (tub, bed bath, shower); shampoo, hair grooming; nail care; oral hygiene; shaving; and dressing;
2. Toileting/bowel and bladder care – assisting to and from bathroom, on and off toilet/commode, diapering, bedpan; external cleansing of perineal area; maintenance bowel care; and changing or emptying catheter bag;
3. Mobility, transfers, comfort – assisting with ambulation with and without aids; repositioning; encouraging active range-of-motion exercises; assisting with passive range-of-motion exercise; and assisting with transfers with or without mechanical devices;
4. Nutrition – preparing meals; planning and preparing special diets; assisting with fluid intake; and feeding; and
5. Medications – assisting with administration of medications; reminding appropriate persons when prescriptions need to be refilled.

15-003.01A Supportive Services: When any of the services listed in 471 NAC 15-003.01, items 1-5 are essential to enable the client to remain in the home and community, the following supportive services may also be provided:

1. Housekeeping tasks necessary to maintain the client in a healthy and safe environment (examples include changing the client’s bed linens, laundering the client’s bed linens and personal clothing, light cleaning in essential areas of the home used by the client; purchasing of food, and cleaning client’s dishes. Note: These housekeeping activities may not be provided for the benefit of any other member of the household.); and
2. Accompanying and assisting the client with any mobility, transfers, or other needed services for physician office visits, or on other trips to obtain medical diagnosis or treatment when the client is unable to travel alone.

15-003.01B Specialized Procedures: Specialized procedures that would enable a person to live in his/her home and community may be performed by a personal assistance service provider at the direction of a competent client or of a caretaker for a minor child or incompetent adult client. Such procedures are considered ‘health maintenance activities’ under the Nebraska Nurse Practice Act (Neb. Rev. Stat. § 71-1, 132.30), and include, for example, insertion and care of catheters; irrigation of any body cavity; application of dressings involving prescription medication and sterile techniques; giving of injections into veins, muscles, or skin; filling insulin syringes; or administration of oxygen. The client’s attending physician or registered nurse must determine that these procedures can safely be performed in the home and community by an approved personal assistance service provider.
under the client’s or caretaker’s direction, the determination must be made for each specific client and his/her approved provider. Form MILTC-4D, “Physician/RN Statement for Health Maintenance Activities,” attached to and incorporated in these regulations, provides a statement of determination for the safety of the health maintenance procedures to be performed by the personal assistance service provider(s) and the competency of the client or caretaker to determine that the provider is qualified to perform the procedure(s) needed.

15-003.01C Services Outside a Client’s Home: Personal assistance services may be provided outside of a client’s home, including at the client’s worksite when the client is engaged in competitive integrated employment. Services provided may only include those authorized tasks that might otherwise be needed in the home and community (for example, assistance with toileting or eating a meal), and if at a worksite, may not be tasks which essentially perform the job the client was hired to do (for example, job coaching). Accompanying and assisting the client with needed services when the client has work-related travels is also allowable.

An individual residing in a licensed residential service program may only be eligible for personal assistance services under this regulation if it is needed to maintain competitive integrated employment or to attend an adult day care program.

15-003.02 Non-Allowable Services: Personal assistance services do not include the following:

1. Personal assistance services not documented in the service plan;
2. Personal assistance services provided by a legally responsible relative, defined as a spouse or parent of a child under 18 years of age;
3. Personal assistance services provided in excess of 40 hours per seven-day period, without prior authorization from Central Office;
4. Housekeeping services that are not an integral part of a covered personal assistance service (examples include cleaning areas of the home not used or occupied by the client, laundry other than that used by the client, preparation of meals for entire household, and shopping for groceries or household items other than those required for the health and maintenance of the client);
5. Services that are not listed as personal assistance services in 471 NAC 15-003.01;
6. Services provided without authorization;
7. A service provided and billed by a provider who is not approved to provide personal assistance services;
8. Companion services, which provide for a person to be present without specific tasks to be completed;
9. Services provided when a client is not Medicaid eligible; and
10. Services that are defined as personal assistance services in 471 NAC 15-003.01 but are being paid by the Department of Health and Human Services Finance and Support under some other arrangement or funding source.
15-004 Eligibility and Authorization

15-004.01 Eligibility Criteria: The Social Services Worker or designee must determine that a client meets eligibility criteria listed on Form MC-73, “Time Assessment and Service Plan,” attached and incorporated, to proceed with the remainder of the authorization process. To be eligible for personal assistance services, a client must meet all of the following criteria:

1. Is a current Medicaid client;
2. Needs personal assistance services to live in the community;
3. Does not have needs that require more intensive services than those listed in 471 NAC 15-003.01 due to an acute health care level;
4. Is not receiving or eligible for personal assistance services or similar staff support based on their residence or place of employment. (An individual residing in a licensed residential service program may only be eligible for personal assistance services under this regulation if it is needed to maintain competitive integrated employment or to attend an adult day care center); and
5. Lives in a residence that is not a hospital, nursing facility, intermediate care facility, prison, or other institution.

15-004.01A Eligibility Criteria for Services in an Adult Day Service: The Social Services Worker or designee must determine that a client meets eligibility criteria listed on Form MS-82 “Adult Day Care Assessment/Authorization,” in order to receive personal assistance services in an adult day service.

15-004.02 Assessment and Service Plan: The Social Services Worker or designee must complete Form MC-73 with the client.

15-004.02A Assessment Process: The Social Services Worker or designee must interview the client to determine eligibility for personal assistance services. Specifically, the Social Services Worker or designee will:

1. Determine if criteria in 471 NAC 15-004.01 is met. This criteria is listed on Form MC-73, and is assessed by asking the client to provide information;
2. Assess the client's specific needs for personal assistance service by asking the client to identify the tasks that s/he is unable to do that are essential to remain in the home and that must be performed by someone else;

3. Determine the services currently being provided and resources meeting any, some, or all of the client's needs by asking the client for this information. This may include determining if there is a need for language interpretation. Personal assistance services are not intended to replace the resources available to a client from their relatives, friends, and neighbors. Additionally, they should not be used to replace other governmental services; and

4. Record all of this information on Form MC-73.

15-004.02A1 Assessment and Authorization Process for Adult Day Services: The Social Services Worker or designee or the adult day service must interview the client to determine eligibility for personal assistance services in the adult day care setting. Form MS-82 must be utilized during this interview, following steps 1 through 4 in 15-004.02, rather than Form MC-73.

15-004.02B Service Plan Process: The Social Services Worker or designee must develop a service plan that identifies the services to be performed for the client. Specifically, the Social Services Worker or designee must complete the following steps, utilizing Form MC-73:

1. Utilizing the list of specific tasks identified in 471 NAC 15-004.02A, item 2, and together with the client, determine the time each task identified will reasonably require;

2. Determine the number of units to be authorized for personal assistance service based on the joint determination of needed tasks and time required;

3. Together with the client, discuss the client's preference for a personal assistance service provider. If the client has a preference of provider(s), the Social Services Worker or designee must include the name(s) on the service plan. It is helpful for the client to have arrangements for an alternative provider, for emergency purposes (see 471 NAC 15-004.03E2); NOTE: A legally responsible relative (spouse or parent/stepparent of minor child) is not allowed to be a personal assistance provider.

4. Together with the client, review and sign Form MC-73; and

5. Give a copy of Form MC-73 to the client and approved provider, and place the original in the client's file.

The client and/or legal guardian must be an integral part of the development of the assessment and service plan by stating their service needs and preferences, and jointly determining the units of service needed.
Physician/RN Statement for Health Maintenance Activities: The Social Services Worker or designee must send Form MILTC-4D, “Physician/RN Statement for Health Maintenance Activities,” to the client’s physician or registered nurse to sign and return, if such specialized procedures as are described in 471 NAC 15-003.01B are needed. Specialized procedures may only be authorized for the client if the client’s physician or registered nurse signs and returns the form to the Social Services Worker or designee.

Service Plan Process for Clients Utilizing Adult Day Care Centers: When personal assistance services will be provided by an adult day care center, the Social Services Worker or designee determines the number of day per week services will be provided and authorizes the service by:

1. Completing Form MS-82; and
2. Sending a copy of the form to the adult day care center.
   NOTE: If the client is receiving both Nursing and Personal Assistance Services at the adult day care center, the Social Services Worker or designee must authorize both under “nursing services days (RN)” on Form MS-82.

Employer Appointment of Agent Form: At this time, before authorization of a personal assistance service provider, the Social Services Worker or designee must obtain the client’s signature on IRS Form 2678, “Employer Appointment of Agent.” This form is only required to be completed once, regardless of the number of approved providers that the client utilizes.

Authorization

Prior Authorization: Personal assistance services must be authorized before actual provision of the service, based on an assessment and service plan.

Limitation: Personal assistance services are limited to a maximum of 40 hours per seven-day period. Only the Social Services Worker or designee, not the approved service provider, may increase the maximum number of units for which the client is eligible per week, within the 40-hour per seven-day maximum. Any services provided in excess of 40 hours per seven-day period must receive prior authorization from Central Office.

Relationship to Service Plan: Personal assistance services authorized must relate directly to the tasks needed to be performed by someone else and that are essential to remain in the home, as listed on Form MC-73.
**15-004.03D Authorization Process:** The Social Services Worker or designee must prior authorize services, and may only do so if s/he has developed a service plan in collaboration with the client, and the document has been signed by the client and the worker.

The Social Services Worker or designee must complete Form MILTC-4B, “Notice and Authorization for Personal Assistance Services,” and give a copy to both the client and personal assistance service provider. The Social Services Worker must list the following information on Form MILTC-4B:

1. Client's name and address;
2. Approved provider’s name, contact information and provider number;
3. Authorized service tasks;
4. Authorization period (up to one year);
5. Authorized units; and
6. Social Services Worker or designee’s name and phone number.

Before the authorization of an approved personal assistance provider, the Social Services Worker or designee must assure that the client has signed an IRS Form 2678, “Employer Appointment of Agent.”

**15-004.03D1 Authorization Period for Client Services:**

1. The Social Services Worker or designee may not authorize services before the date that client eligibility for the service is determined.
2. The Social Services Worker or designee must authorize services based on the client’s service needs for a period not to exceed a maximum of one year from the service authorization begin date.
3. To continue receiving services after the expiration of the authorization period, the Social Services Worker or designee must reauthorize services. (See 471 NAC 15-004.04)

**15-004.03D2 Authorization Period of Providers:** The Social Services Worker or designee may only authorize a provider until the end date of the client’s existing authorization for services.

**15-004.03D3 Authorization of Multiple Providers:** The Social Services Worker or designee must, with the client, determine the maximum number of units each provider will be authorized to provide. It is the client’s responsibility to determine the day-to-day schedule of each provider.

**15-004.03E Emergency Authorization for Clients Already Receiving Personal Assistance Services:** If a client’s approved provider becomes unavailable with little or no notice, and the client is in need of the authorized service immediately, the Social Services Worker or designee may need to authorize an alternative provider without having completed the provider approval process described in 471 NAC 15-006.03.
15-004.03E1 Limitation: The Social Services Worker or designee may not authorize an alternative provider before the first date of the original provider's unavailability.

15-004.03E2 Client's Responsibilities: In order to receive emergency approval for an alternative provider, the client must:

1. Find a provider and inform him/her of the authorized services to be provided, as well as the need to go through the Department approval process in order to receive payment for services; and
2. Notify the Social Services Worker or designee of the situation and contact information for the alternative provider within one working day of finding the alternative provider.

15-004.03E3 Department Responsibilities: Once the Social Services Worker or designee is notified of the alternative provider, s/he must:

1. Immediately authorize the alternative provider to provide personal assistance services for the client, using the process described in 471 NAC 15-004.03D;
2. Send Form MILTC-4B to the alternative provider and the client; and
3. Notify the local office provider approval staff or their designee within three working days of the need to initiate the provider approval process.

15-004.03E4 Initiation of Alternative Provider Approval: The local office provider approval staff or designee must initiate the provider approval process described in 471 NAC 15-006.03D within three working days of notification by the Social Services Worker or designee.

15-004.03E5 Denying Approval of Alternative Provider: If the alternative provider cannot be approved due to inability to meet criteria listed in 471 NAC 15-006.01, s/he will only be paid for services provided up to and including the day that this determination is made. In this situation, the Social Services Worker or designee must notify the alternative provider and the client in writing and terminate the provider authorization within 10 working days of the determination.

15-004.04 Review of Service Plan and Re-Authorization: Personal assistance services must be re-authorized at the end of an authorization period, which is at least annually, based on continued eligibility and a review of the service plan. The Social Services Worker or designee must review the service plan together with the client a minimum of once every 12 months, or whenever the client's service needs change.
The Social Services Worker or designee must contact the client in writing at least 30 days before the end of the 12-month period to request a review of the service plan. If the client does not respond, his/her service authorization will expire.

If the client desires his/her service provider(s) to participate in the review, the client must inform the Social Services Worker or designee, who must then make arrangements for this to occur. At the review, if the client continues to meet eligibility requirements, the Social Services Worker or designee must:

1. Complete a new Form MC-73, or initial and date the existing Form MC-73 if no changes are needed;
2. Complete Form MILTC-4B; and
3. Give a copy of Forms MC-73 and MILTC-4B to the client and provider(s), and place the originals in the client’s file.

15-004.04A Review and Reauthorization in an Adult Day Service: The Social Services Worker or designee or the adult day care center must review Form MS-82 with the client to determine the continued need for service. This re-assessment must be done a minimum of every 12 months or when ever the client’s service needs change. Either a new Form MS-82 must be completed, or the existing Form MC-73 must be initialed and dated if no changes are needed.

15-005 Client Rights and Responsibilities

15-005.01 Client Rights: Clients who are found to be eligible for personal assistance services have the right to:

1. Identify their service needs;
2. Determine their preferred approved provider, which may include selecting from a Medicaid-approved list of providers;
3. Identify a possible provider who meets minimum qualifications as described in 471 NAC 15-006.01, but who is not yet approved to provide services;
4. Direct their personal assistance services;
5. Receive services according to the service plan, free from risk of harm or exploitation, including physical and verbal abuse, theft and misuse of household belongings, personal funds, prescriptions or other medical supplies; and
6. Evaluate their personal assistance service provider(s) in the authorized task(s).

If the client is not able to exercise these rights, a designated responsible party who is able to perform these functions for the client may do so.

15-005.02 Client Responsibilities: Clients receiving personal assistance services have the responsibilities to:
1. Disclose necessary medical information to the personal assistance service provider to allow for the safety of both the client and provider;
2. Notify the Social Services Worker or designee of any changes in their medical condition or service needs;
3. Schedule provider(s) within the parameters of the Authorization Notice;
4. Notify the Social Services Worker or designee if the provider is not performing the tasks for which s/he is authorized;
5. Notify the Social Services Worker or designee of any harm or exploitation by the provider, including physical and verbal abuse, theft and misuse of household belongings, personal funds, prescriptions or other medical supplies;
6. Approve all provider payments by signing Form MC-37, “Service Provider Time Sheet,” if the information on the form is accurate;
7. Sign the IRS Form 2678, “Employer Appointment of Agent”;
8. Be at home or other designated location when the provider arrives to carry out scheduled authorized tasks;
9. Ensure that the provider is free from risk of harm while performing the authorized tasks;
10. Follow the terms of the service plan and Form MILTC-4B, “Notice and Authorization for Personal Assistance Services,” which specify the parameters of reimbursable personal assistance services and providers;
11. Formulate a back-up plan for provision of services in case of provider emergency; and
12. If a provider emergency arises, initiate the back-up plan for provision of services.

15-005.03 Client Notification: The Social Services Worker or designee must send written notice of denial, reduction, or termination of services to the client/guardian. Most often, the notice used is Form HHS-6 or a computer-generated notice. Notice to clients/guardians must contain:

1. A clear statement of the action to be taken;
2. A clear statement of the reason for the action;
3. A specific regulation citation which supports the action; and
4. A complete statement of the client/guardian’s right to appeal.

Notice of reduction or termination of services must be mailed at least ten calendar days before the effective date of action. Exception: If the termination of personal assistance services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility.

15-005.03A Changes to Authorization: The Social Services Worker or designee must notify the client in writing of any change in the authorized service, including:

1. Change in service tasks to be provided;
2. Change in authorized units;
3. Change in approved provider; or
4. Change in authorization period.
The Social Services Worker or designee must send an updated Authorization Notice to the client within five working days of the change.

15-005.03B Denial/Termination Reasons: The Social Services Worker or designee must provide notice of denying or terminating eligibility for the following reasons:

1. The client has no personal assistance service need;
2. The client’s needs are being met by another source;
3. The client/guardian has not supplied needed information to complete the eligibility process;
4. The client fails to meet the specified eligibility criteria in 471 NAC 15-004.01;
5. Specific component(s) of the service plan (e.g., services to be provided, number of units to be authorized) cannot be agreed upon by the Social Services Worker or designee and the client;
6. The client/guardian voluntarily withdraws;
7. The client moves out of Nebraska;
8. The client dies;
9. The Department loses contact with the client and his/her whereabouts are unknown;
10. The client has not made him/herself available to the provider(s) at scheduled times by being home or at other designated locations, three or more times in a 30-day period;
11. The client or household member has demonstrated violence toward the provider(s);
12. The client has provided an unsafe and dangerous environment in which the provider(s) has been expected to work; or
13. An authorization period is ending and the client/guardian has not acted upon a written notice of the need for re-authorization.

15-005.03C Advance Notice Not Required: The Social Services Worker or designee must provide a notice of action to close a case (Form HHS-6 or computer generated notice), but notice may be provided without the ten-day advance in the following situations:

1. The Social Services Worker or designee has factual information confirming the death of a client;
2. The Social Services Worker or designee receives a clear written statement signed by a client that he/she no longer wishes services;
3. The client has been admitted to a nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease;
4. The client’s whereabouts are unknown; or
5. The Social Services worker or designee establishes the fact that the client has been accepted for Medicaid services by another state.
15-005.03D Provider Notice: When a client’s personal assistance services are being changed in any way or terminated, the Social Services Worker or designee must provide written notice to the provider of the change in service provision or termination of payment for personal assistance services (Form MILTC-4C or computer-generated notice).

15-005.04 Client Appeals of Adverse Actions: Persons who request, apply for, or receive services may appeal any adverse action or inaction of the Department. These may include a potential client being denied personal assistance services, a client’s services being reduced, or a client being determined ineligible for continued personal assistance services or other similar decisions. The Department of Health and Human Services must provide opportunities for fair hearings as defined in 42 CFR 431, Subpart E, to clients or their legal representatives who are denied personal assistance services (see 465 NAC 2-001.02 and 6-000).

15-006 Provider Requirements

15-006.01 Basic Provider Qualifications: To become an approved personal assistance provider, an applicant must:

1. Be age 19 or older;
2. Agree to all General Provider Standards listed on Form MC-19, “Service Provider Agreement,” (see 471 NAC 15-006.01A);
3. Not be an employee of the Department or its designees if s/he is in a position to influence his/her own approval or utilization;
4. Not be a relative of the Department staff person or designee responsible for his/her approval as a personal assistance service provider. (NOTE: In situations where a Department staff person’s or designee’s relative is the only resource, staff must obtain approval from the HHS Service Area Long-Term Care Administrator);
5. Be capable of recognizing signs of distress in client and know how to access available emergency resources if a crisis situation occurs;
6. Not be a recipient of personal assistance services for the tasks s/he is being paid to perform; and
7. If the provider is an Adult Day Service, maintain all standards and requirements outlined in 473 NAC 5-002.

15-006.01A General Provider Standards: As listed on Form MC-19, an approved provider must agree to:

1. Follow all applicable regulations in Nebraska Administrative Code Titles 465, 471, 473, 474, and 480;
   a. Bill only for services which are authorized and actually provided.
   b. Comply with the requirements of 471 NAC 3 for the submission of claims for payment.
2. Accept payment as payment in full (payment from the Department of Health and Human Services Finance and Support plus the client's obligation) and assure that the rate negotiated or charged does not exceed the amount charged to private payers;
3. Not provide services if s/he is the legally responsible relative (for example, spouse of client or parent of minor child who is a client);
4. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60;
5. Retain financial and statistical records for four years from date of service provision to support and document all claims;
6. Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.72 – 74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site;
7. Keep current any state or local license/certification required for service provision;
8. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State;
9. Agree and assure that any false claims (including claims submitted electronically), statement, documents, or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18);
10. Respect every client's right to confidentiality and safeguard confidential information;
11. Understand and accept responsibility for the client’s safety and property;
12. Not transfer this agreement to any other entity or person;
13. Operate a drug free workplace;
14. Not use any federal funds received to influence agency or congressional staff;
15. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect;
16. Allow checks as required in 471 NAC 15-006.03A1 on him/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place;
17. Have the knowledge, experience, and/or skills necessary to perform the task(s);
18. Report changes to appropriate Department staff (i.e., no longer able/willing to provide service, changes in client function); and
19. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate Department staff.
15-006.02 Specialized Provider Qualifications: A personal assistance service provider is considered to be "specialized" when s/he provides proof of one or more of the following:

1. Has successfully completed a basic aide training course that has been approved by the Nebraska Department of Health and Human Services;
2. Has passed the Nurse Aide Equivalency test;
3. Is a licensed R.N. or L.P.N. and presents a copy of the certificate or license to the worker; or
4. Has a total of 4,160 hours of experience (24 months at an average of 40 hours per week) as a personal assistance service provider.

A copy of the applicable certificate or license, or evidence of hourly experience—pay stubs or letter of verification from former employer(s)—must be presented to the local office provider approval staff, or their designee, who will make a copy to place in the applicant's file and then forward the document to Central Office with Form MILTC-9.

15-006.03 Provider Approval Process: The local office provider approval staff, or a designee, must initiate the approval process by completing Form MILTC-9, “Service Provider Agreement,” and Form MC-84, “Personal Assistance Service Provider Checklist,” with the provider applicant. Approval is not complete until Form MILTC-9 and any supporting documentation are sent to Central Office for review and approval.

Specifically, the following tasks must occur to approve a personal assistance service provider:

15-006.03A Initial Meeting: Local office provider approval staff or designee meets with the provider applicant and:

1. Completes Form MILTC-9 to determine if the applicant meets minimum qualifications and agrees to carry out all provider responsibilities. The provider approval staff or designee must explain each provider responsibility listed on Form MILTC-9;
2. Completes Form MC-84 at this meeting and throughout the approval process to assure that all required steps are completed; and
3. Gives the provider applicant a provider handbook and explains the contents of the handbook. Also gives the provider applicant copies of the completed MILTC-9 and MC-84 forms, assuming the applicant meets all requirements on both forms.

15-006.03A1 Requirements to Assure Criminal History and Protective Service Compliance by Providers: The local office provider staff or designee must not issue initial provider approval or must terminate an existing approval if the provider applicant indicates a history of conviction(s) regarding misdemeanor or felony actions which may endanger the health or safety of any client. This includes crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving
the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider.

No provider approval will be issued or remain in effect if a registry/website report on the provider applicant as a perpetrator is shown as ‘investigation in progress’ or ‘inconclusive’ (CPS) or ‘substantiated’ (APS).

**15-006.03A1a Individual Providers:** Prior to approval at both the initial approval and renewal, the local office provider staff must complete the following:

1. Obtain a criminal history statement from the provider applicant. This statement must identify any record of any felony or misdemeanor convictions. This must include details, dates, and disposition (e.g., parole, probation, incarceration, fine, community service, etc.);
2. Perform a criminal background check of the provider prior to provider approval; and
3. Clear the name of the provider applicant against the HHS Adult Protective Services Central Registry, the HHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offender Website, and the Nurse Aide Registry.

**15-006.03A1b Agency Providers:** If the provider is an agency, the local office provider staff or designee must:

1. Review the policy of the agency to determine that safeguards are in place to protect the well-being of clients. All agency providers must have a policy that fully states the agency’s practice in assuring that safeguards are in place to protect the well-being of clients.
2. Review evidence that the agency’s employees have been cleared against the HHS Adult Protective Services Central Registry, the HHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offender Website, and the Nurse Aide Registry. Each agency provider must have a policy to determine how information found via these registries/website is used for its employees. This policy must assure that no staff person identified through this process poses a danger to the health and safety of any client. At the time of renewal, the provider approval staff or designee must review evidence that the agency continues to follow their established procedures in regard to these registries and newly-hired staff.

**15-006.03A2 Specific Criminal History:** The local office approval staff or designee must deny or terminate service provider approval when charges are pending or conviction has occurred in the following areas:
1. Child pornography;
2. Child sexual abuse;
3. Driving Under the Influence:
   a. For providers of transportation services, a DUI charge is pending or a conviction has occurred within the past eight years.
   b. For providers of non-transportation services, two or more DUI charges are pending, or convictions have occurred within the last five years, or two of any combination of DUI charges pending or convictions occurred within the last five years.
4. Domestic violence;
5. Shoplifting after age 19 within the last three years;
6. Felony fraud within the last ten years;
7. Misdemeanor fraud within the last five years;
8. Termination of provider status for cause from any HHS program within the last 10 years;
9. Possession of any controlled substance within the last five years;
10. Possession of a controlled substance with intent to deliver within the last five years;
11. Felony or misdemeanor assault without a weapon in the last 10 years;
12. Felony or misdemeanor assault with a weapon in the last 15 years;
13. Prostitution or solicitation of prostitution within the last five years;
14. Felony or misdemeanor robbery or burglary within the last 10 years;
15. Rape or sexual assault; or

Other pending charges or convictions are considered using the guidance of the general policy stated in 471 NAC 15-006.03A1 and weighted to similar offenses included in this list.

If criminal history and protective service compliance are met, the local staff or designee sends original copies of the MILTC-9 and any documentation that verifies training received to Central Office for final approval.

15-006.03B Central Office Provider Approval: Central Office staff will:

1. Receive Forms MILTC-9;
2. Receive and review any documentation of training or experience to verify qualifications for the specialized rate;
3. Assign a rate of pay (basic or specialized) if all documentation meets requirements;
4. Generate a unique provider identification number;
5. Send a letter of notification that the provider is now approved to the local staff person or designee and the provider;
6. Notify the local office or designee of any missing elements if all the required documentation is not received, and place the provider approval process on hold until proper documentation is received; and

7. Send the provider a supply of Forms MC-82, “Personal Assistance Service Provider Claim Form,” and MC-37, “Service Provider Time Sheet,” with explanation.

The Social Services Worker or designee may then authorize the provider for personal assistance services.
15-006.03B1 Adult Day Service Providers: If the provider is an adult day service, the local office staff person or designee must have the adult day service contact Central Office to complete a Medicaid Provider Agreement, designating the center’s personal assistance provider. Once this is completed, the local staff person or designee must send the provider a supply of:

- 1. Form MC-82AD, “Adult Day Care Nursing/Aide Services Claim forms” instead of Form MC-82. This form is specifically tailored for claims by adult day care centers; and
- 2. Form MS-82, “Adult Day Care Assessment/Authorization”. This is an assessment that the adult day care center must conduct with the client to determine the specific personal assistance tasks that must be completed for the client while at the adult day care center.

15-006.03C Denying a Provider Applicant: If the local office provider approval staff or designee or Central Office determines that the provider applicant does not comply with all the provider qualifications for the service to be provided, the staff or designee must:

1. Document the regulation(s) on which the denial is based and the reason(s) why the provider applicant does not comply with the cited regulations; and
2. Send a letter of notice to the potential provider including:
   a. Explanation of the reasons for the Department’s determination that the provider applicant does not comply with the cited regulations, or that the Department and the provider applicant have failed to agree on contracting issues;
   b. Citation of the regulations on which the denial was based; and
   c. Notification of the provider applicant’s right to appeal the Department’s decision/action (see 471 NAC 15-006.03F).

15-006.03C1 Voluntary Withdrawal: Written notice to the provider applicant is not required if s/he voluntarily withdraws from the approval process.

15-006.03D Provider Termination: The Department may terminate a provider agreement by giving at least 30 days advance written notice. If the provider violates or breaches any of the provisions of the Service Provider Agreement, then the Department may terminate the agreement immediately.

When an agreement is to be terminated by the Department, the local office provider approval staff or designee must:
1. Document the reason(s) for the termination; and
2. Provide written notice which includes:
   a. Explanation of the reasons for the termination;
   b. Citation of the regulations on which the termination was based; and
   c. Notification of the provider’s right to appeal the Department’s decision/action.

15-006.03D1 Termination by a Provider: The provider may terminate an agreement by giving at least 30 days advance written notice. The 30-day requirement may be waived in case of emergencies such as illness, death or injury.

When terminating an agreement, a provider must:

1. Give written notice of the need for termination to the local office provider approval staff or designee; and
2. Document the effective date for termination, giving at least 30 days advance notice.

15-006.03E Client Notice of Provider Termination: The local office provider approval staff or designee must notify the Social Services Worker or designee of all clients being served by the provider of his/her termination.

The client’s Social Services Worker or designee must notify the client immediately and work with the client to find a new provider (see 471 NAC 15-004.03D). If provider termination was done under emergency circumstances, the client and Social Services Worker may utilize the process described in 471 NAC 15-004.03E to find and approve an alternative provider.

15-006.03F Provider Appeals: All Medicaid providers have the right to appeal any decision/action that has a direct adverse effect on the provider (see 471 NAC 2-003). Hearings are scheduled and conducted according to the procedure in 465 NAC 2-001.02 and 6-000. Appealable actions include a determination that a provider standard is not met, disallowance of a claim, or other adverse decisions. Providers may not appeal service authorization terminations related to a client’s eligibility or choice of provider.

15-006.04 Provider Agreement Renewal: The local office provider approval staff or designee must use the steps in 471 NAC 15-006.03 to re-evaluate each service provider. However, an in-person meeting is not required for renewal. Provider agreements must be renewed at least annually before the expiration of the Service Provider Agreement.

15-006.05 Provider Responsibilities: An approved provider must:
1. Adhere to all General Provider Standards in the Service Provider Agreement (see 471 NAC 15-006.01A);
2. Perform the personal assistance services described on the service plan;
3. Ensure that personal assistance services are provided in a manner that is consistent with the client’s choice and desire to live independently;
4. Participate in the review of the client’s service plan as described in 471 NAC 15-004.04, if and when the client requests him/her to participate;
5. Be sensitive to the client’s needs;
6. Recognize changes in the client’s condition as it relates to the service plan, and report them to the Social Services Worker or designee;
7. Submit billing on Form MC-82, “Personal Assistance Service Provider Claim Form,” only for personal assistance services provided;
8. Accurately document services related to the service plan that are provided to and on behalf of the client on Form MC-37, “Service Provider Time Sheet,” and submit with Form MC-82 for payment;
9. Disclose necessary medical information to all clients for whom services are being provided, to allow for the safety of both client and provider;
10. Not apply physical restraints to the client unless documented in the service plan;
11. Retain the following materials for four years:
   a. Documentation that supports provision of services to each client served;
   b. Any other documentation determined necessary by the Department to support selection and provision of services under a service plan;
   c. Financial information related to the personal assistance services that are necessary to allow for an independent audit under Medicaid;
   d. Documentation that supports requests for payment; and
   e. Provider agreements with the Department.
12. Give adequate notice to the client when unable to provide scheduled services.
13. Not harm or exploit the client or client’s household members, including acts of physical or verbal abuse, theft, or misuse of household belongings, personal funds, prescriptions or other medical supplies;
14. In an emergency situation, attempt to locate temporary coverage when unable to provide scheduled services;
15. If the provider is an adult day service, submit billing on Form MC-82AD; and
16. If the provider is an adult day service, complete Form MS-82 for each client being provided personal assistance services with the client, and submit to the client’s Social Services Worker for review.

15-006.06 Provider Payment Process: Before authorizing a personal assistance service provider, the Social Services Worker must obtain the client’s signature on IRS Form 2678, “Employer Appointment of Agent,” in order to withhold taxes from the provider on behalf of the client, if appropriate.

To receive payment after personal assistance services are provided, the provider must:
1. Complete Form MC-37 which allows the provider to record the starting and ending times and a description of services provided each day;
2. Complete Form MC-82 for each client receiving personal assistance services, for the same time period as that reflected on Form MC-37;
3. Sign both forms;
4. Obtain the client’s signature on Form MC-37; and
5. Submit both forms to the client’s Social Services Worker or designee.

15-006.06A Billing by Adult Day Service Providers: Adult day services must complete Form MC-82AD instead of Form MC-82 to claim payment and are not required to submit time sheets specifically for personal assistance services.

15-006.06B Frequency of Billing: Providers may not bill more than one time per week but must bill at least monthly.

15-006.06C Social Services Worker Actions: After receiving both forms, the client’s Social Services Worker or designee must:

1. Verify that the hours worked and services provided fall within the parameters of those authorized;
2. Sign both forms, including documentation of authorized units in the “Local Office Use Only” section of Form MC-82;
3. Copy both forms for the client’s and provider’s files; and
4. Send Form MC-82 to the Claims Payment Unit in the Department of Health and Human Services Finance and Support within three days of receiving it from the provider.

15-006.06D Claims Payment Actions: The Claims Payment Unit must:

1. Enter the dates and units of service into the Medicaid Management Information System (MMIS); and
2. Process the claim for payment.

15-006.06E Provider Rates: The Central Office determines rates on a statewide basis. These rates are contained in the Nebraska Medicaid Personal Assistance Service Rate Listing (see 471-000-515). The Department has the authority to adjust the rate schedule.

15-006.06E1 Adult Day Service Rate: A specific rate for adult day services providing personal assistance service is determined by Central Office.
15-006.06F Authorization for Payment:

1. The Social Services Worker or designee must prior authorize payment for personal assistance services. Authorization to provide services and to receive payment for personal assistance services is effective on the date that Form MILTC-9 is signed and dated by the Social Services Worker or designee.

2. Retroactive payment is not allowed.

   EXCEPTION: Only in circumstances where emergency authorization of a provider is necessary, it is allowable to pay an alternative provider for services provided before approval and authorization is completed (see 471 NAC 15-004.03E).

3. If electronic prior authorization requests are submitted, the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) must be used. If electronic claims are submitted, the appropriate standard electronic format (ASC X12 837) must be used.

15-006.06G Provider Social Security Tax Withholding:

15-006.06G1 Affected Providers: In some situations, the Department of Health and Human Services Finance and Support withholds Social Security taxes (Federal Insurance Contribution Act, FICA) from provider payments. The employee’s share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. The Department of Health and Human Services Finance and Support, upon receiving a signed IRS Form 2678, “Employer Appointment of Agent,” acts on behalf of clients who receive in-home services to withhold mandatory FICA taxes from individual providers and pays the client’s matching tax share to the Internal Revenue Service (IRS).

15-006.06G2 Earnings Taxed for Social Security: Affected providers are subject to Social Security tax payment for each calendar year in which they are paid a federally determined amount or more for services provided to one client. (For example, for calendar year 2002 the base amount was $1,300 paid for FICA-covered services per client.) The Department of Health and Human Services Finance and Support must withhold this tax from all payments to affected providers. If a provider’s earnings do not reach this annual amount for FICA services per client, the amount withheld for that year is refunded to the provider.

15-006.06G3 Social Security Tax Rates: The Department of Health and Human Services Finance and Support remits to the IRS an amount equal to the current Social Security tax rate for specified “in-home” services. Half of this amount is withheld from the provider as the employee’s share; the other half is provided by the Department of Health and Human Services Finance and Support on behalf of the client employer.
CHAPTER 16-000 PHARMACY SERVICES

16-001 Standards for Participation: A provider of pharmacy services shall be a licensed pharmacy, licensed pharmacist, or dispensing physician. To participate in the Nebraska Medical Assistance Program (NMAP), the provider shall fully meet the standards established by the Department of Health and Human Services and any applicable state and federal laws or regulations governing the provision of the service. Providers shall meet all the Department's pharmacy regulations contained in this chapter.

The pharmacy provider shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit it to the Department to be approved for provider enrollment. Approval may be denied or withdrawn at the discretion of the Director.

16-001.01 Drug Utilization Review: As a condition of participation, the provider is required to:

1. Provide prospective drug utilization review before dispensing each prescription. This shall include screening for:
   a. Therapeutic duplication;
   b. Drug disease contraindications;
   c. Drug interactions;
   d. Incorrect dosage or duration;
   e. Drug allergies; and
   f. Clinical abuse/misuse; and

2. Provide patient counseling on all matters which, in the provider's professional judgment, are deemed significant, including:
   a. Name/description of the medication;
   b. Route, dosage form, duration of therapy;
   c. Directions for use;
   d. Adverse reactions, contraindications;
   e. Storage; and
   f. Refill information; and

3. Maintain adequate patient profiles which may include:
   a. Name, address, phone number, date of birth, and gender;
   b. Individual history (i.e., diseases, allergies, drug reactions)
   c. Comprehensive listing of medications; and
   d. Relevant comments.
16-002 Covered Services: NMAP covers outpatient drugs in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Public Law 101-508) including:

1. Legend drugs;
2. Compounded prescriptions; and
3. Over-the-counter (OTC) drugs indicated as covered on the Nebraska Point of Purchase (NE-POP) System or listed on the Department’s website.

16-002.01 Compounded Prescriptions: A compounded prescription is a mixture of ingredients which the provider prepares in the pharmacy. (See the NE-POP System User’s manual for billing instructions.)

Reimbursement for compounded prescriptions will be limited to those ingredients which are indicated as covered on the NE-POP System or listed on the Department’s website.

Any mixture of drugs which results in a commercially available OTC preparation is not considered a compounded prescription, for example, dilute HCL, MOM with cascara, OTC hydrocortisone preparations.

16-002.02 Over-the-Counter (OTC) Drugs: NMAP covers only OTC drugs indicated as covered on the NE-POP System or listed on the Department’s website. OTC drugs shall be prescribed by a licensed practitioner.

16-002.03 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act shall meet the conditions of items 1 through 6 listed in the definition of “Treatment Services” in 471 NAC 33-001.04. These services shall be prior authorized by the Division of Medicaid and Long-Term Care of the Department of Health and Human Services.

16-002.04 Tobacco Cessation Counseling: In addition to a physician/mid-level practitioner, only a licensed pharmacist, meeting Department conditions of participation in 471 NAC 16-002.04A as a Tobacco Cessation Counselor, may provide tobacco cessation counseling.

16-002.04A Tobacco Cessation Counseling – Conditions of Participation: As a condition of participation as a Tobacco Cessation Counselor, the provider shall:

1. Be a licensed pharmacist;
2. Complete a Department-approved tobacco cessation counselor training;
3. Maintain current training as a Tobacco Cessation counselor as required by the Department;
4. Complete and sign a new provider agreement (Form MC-19), indicating the employing pharmacy as the "pay to" provider, and submit proof of completing the Department-required training as part of the provider agreement completion process, or upon request by the Department;
5. Provide Tobacco Cessation counseling which is separate and distinct from the prospective drug utilization review that is required in 471 NAC 16-001.01 and is not related to the dispensing of any drug product; and

6. Provide feedback to the physician/mid-level practitioner who ordered the services.

16-002.05 Prescription Refills: Prescription refills shall be performed and recorded in a manner consistent with existent State and Federal laws, rules and regulations. Automatic refills are not allowed. All prescription refills shall be initiated by a request from the prescriber, client, or other person acting as an agent of the client, i.e., family member. In the event the client is residing in a facility, a nurse or other authorized agent of the facility pursuant to a valid prescriber’s order may initiate the request for refill.
16-003 Non-Covered Services: Payment by NMAP will not be approved for:

1. Requests for quantities not in compliance with 16-004.07.
2. Experimental drugs or non-FDA approved drugs;
3. Drugs or items when the prescribed use is not for a medically accepted indication;
4. Drugs or items prescribed or recommended for weight control and/or appetite suppression;
5. Liquors (any alcoholic beverage);
6. Drug Efficacy Study Implementation Program (DESI) drugs identified as Less Than Effective or Identical, Related or Similar (LTE/IRS) with an indicator value assigned by the FDA of either 5 or 6;
7. Personal care items (examples: non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, and contact solutions);
8. Medical supplies and certain drugs for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) patients (see 471 NAC 7-000 and 16-004.05);
9. Over-the-counter (OTC) drugs not listed on the Department's website;
10. Drugs or items used for cosmetic purposes or hair growth;
11. Baby foods, milk substitutes or metabolic agents (Lofenalac, etc.,) normally supplied by Nebraska Department of Health and Human Services (see 471 NAC 16-002.03 for exceptions);
12. Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the drug rebate program;
13. Products used to promote fertility;
14. Medications dispensed as partial month fills for nursing facility or group home residents when dispensed by more than one pharmacy;
15. Medications dispensed to replace products which have been recalled by the drug manufacturer;
16. Drugs, items or products of manufacturers/labelers that are identifiable as non-covered on the NE-POP System or on the Department’s website;
17. Drugs, classes of drugs or therapeutic categories of drugs that are Medicare Part D Drugs and Medicare Part D Covered supplies or equipment, for all persons eligible for benefits under Medicare Part D, whether or not such persons are enrolled into a Medicare Part D Plan (see 471 NAC 3-004 for definitions of Medicare Part D Drugs, Medicare Part D Covered supplies and equipment, Medicare Part D and Medicare Part D plan);
18. Drugs or classes of drugs approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction, or drugs or classes of drugs that are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs that are approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction and for conditions other than treatment of sexual or erectile dysfunction, and are prescribed for those other conditions may be covered, but NMAP may require prior authorization. (See 471 NAC 16-004); and
19. Automatic refills. (See 471 NAC 16-002.05).
16-004 Limitations and Requirements for Certain Services

16-004.01 Prior Authorization: The Department requires that authorization be granted prior to payment for certain drugs. Should a practitioner dispense a prescription prior to the actual authorization he/she takes a business risk that payment for the prescription may be denied. Providers that are prescribing these drugs or pharmacists that are dispensing these drugs shall obtain prior authorization by submitting the request by standard electronic transaction or by phone, fax or mail, from either:

1. The Department’s NE-POP contractor; or
2. The Pharmacy Consultant (or designee)
   Nebraska Department of Health and Human Services
   Division of Medicaid and Long-Term Care
   P O Box 95026
   301 Centennial Mall South, 5th Floor
   Lincoln, NE 68509-5026
   Phone: (877) 255-3092
   Fax (402) 742-2348

The NE-POP contractor or the Department will respond to any request for prior authorization within 24 hours of receipt of the request. In cases of medical emergency, provisions are made for dispensing a seventy-two (72) hour supply of a covered outpatient prescribed medication.

16-004.01A Approval Decision: The NE-POP contractor or the Department will notify the provider prescribing the drug or the pharmacy dispensing the drug if the authorization has been granted, the eligible dates of the authorization, and the identification of the provider who requested the authorization. The prior authorization is given for the drug, the client, and the prior authorization dates.

16-004.01B Denial Decision: The NE-POP contractor or the Department will notify the provider prescribing the drug or the pharmacy dispensing the drug if coverage is denied.

16-004.01C Emergency Decision: The NE-POP contractor or the Department will authorize dispensing up to a seventy-two (72) hour supply of a covered outpatient prescribed medication for cases meeting the definition of a medical emergency as outlined in 471 NAC 2-004.04A.

16-004.01D Unknown Decision: If the provider that is prescribing the drug or the pharmacy that is dispensing the drug has not received an authorization from the NE-POP contractor or the Department, payment may be denied.

16-004.01E Verifying Status of Requests: The status of prior authorization requests for drugs may be verified by the pharmacy by submitting a claim via the NE-POP System. If the prior authorization request has not been approved, the pharmacy may contact the NE-POP contractor or the Department for prior authorization.
16-004.02 Products Requiring Prior Approval: Identifiable products requiring approval prior to payment are designated as such on the NE-POP System or on the Department’s website. There are three reasons for the use of prior authorization; product based controls, utilization controls and scope controls.

1. Product Based Controls. Prior authorizations that fall under this category are products where there are medically appropriate alternative treatments which are more cost-effective for the Department.

2. Utilization Controls. Prior authorizations that fall under this category generally apply to the quantity of medication or duration of therapy approved.

3. Scope Controls. Scope controls are used to ensure a drug is used for an approved or medically accepted indication, is clinically appropriate, medically necessary and cost-effective.

   a. Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one of the approved indications places that drug in a therapeutic category or treatment class for which a prior authorization is required; or

   b. Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration; or

   c. Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

16-004.03 Preferred Drug List and Pharmaceutical and Therapeutics Committee

16-004.03A Preferred Drug List (PDL): The Medicaid Prescription Drug Act of 2008 requires the Department to establish and maintain a Preferred Drug List for the Medicaid program with the aid of the Pharmaceutical and Therapeutics Committee. Individual drugs will be designated as Preferred or Non-Preferred within therapeutic classes of prescribed drugs reviewed by the Pharmaceutical and Therapeutics Committee. Drugs designated as Preferred Drugs may be prescribed for Medicaid clients without prior authorization from the Department; however some Preferred Drugs may have clinical claim limits to ensure appropriate use. The Preferred Drug List and other related activities shall not be construed to replace, prohibit, or limit other lawful activities of the Department not specifically permitted or required by the Act. Drugs classified as Preferred Drugs will be eligible for Supplemental Rebates as described under the provision of 471 NAC 1-002.02M7.
The Department will include on the Preferred Drug List prescribed drugs that are found to be therapeutically equivalent to or superior to other drugs within a therapeutic class, and the net cost of the drugs are equal to or less than other drugs within a therapeutic class after consideration of applicable rebates or discounts negotiated by the Department or its designated contractor. All classes of medications shall be considered for inclusion on the PDL except the antidepressants, antipsychotics or anticonvulsant medications.

Medications designated as non-preferred on the Preferred Drug List will be subject to Prior Authorization. The Pharmaceutical and Therapeutics Committee will develop criteria for use of medications with non-preferred status.

A health care provider may prescribe a drug designated as non-preferred on the Preferred Drug List to a Medicaid client without prior authorization by the Department if the provider certifies that:

1. The client is achieving therapeutic success with a course of medication for human immunodeficiency virus, multiple sclerosis, cancer, or immunosuppressant therapy; or
2. The client has experienced a prior therapeutic failure with a medication designated as a Preferred Drug.

The Department will maintain an updated Preferred Drug List in electronic format and will make the list available to the public from the Department’s website. Drugs and classes of drugs included on the PDL will be reviewed annually. Changes will be communicated to providers at least 30 days prior to implementation.

16-004.03B Pharmaceutical and Therapeutics Committee (P & T Committee): The Department will establish a Pharmaceutical and Therapeutics Committee to review certain classes of drugs for efficacy, safety and cost, for inclusion on or exclusion from the Department’s Preferred Drug List. The Pharmaceutical and Therapeutics Committee will advise the Department on all matters related to the Preferred Drug List.

The members of the Pharmaceutical and Therapeutics Committee will be appointed by the Director of the Division of Medicaid and Long-Term Care. The members will meet the requirements as set forth in the Medicaid Prescription Drug Act of 2008. Members of the Committee will be reimbursed for their actual and necessary expenses.

The Pharmaceutical and Therapeutics Committee will receive and review data as reviewed and approved by the Department’s Pharmacy Consultant. The data shall include information about each drug’s efficacy relative to other drugs in the class being reviewed and the relative safety of each drug. After drugs or drug classes have been reviewed and their efficacy and safety determined, the net cost of each may be provided by the Department’s Pharmacy Consultant to the Committee, if needed, in order to determine a Preferred Drug. The drug net cost may be provided to allow comparability, such as on the net cost per day of therapy. Drug rebates and supplemental drug rebates will be included in the drug net cost determination.
All Pharmaceutical and Therapeutics Committee meetings will be open to all interested parties. Public comments will be allowed, but may be constrained by necessity by time or other resources. The Preferred Drug List Program Coordinator shall develop an agenda for each meeting and make it available to all interested parties at least 30 days before the meeting. Pharmaceutical and Therapeutics Committee meetings or portions thereof may not be open to all interested parties if confidential material is being covered, such as Unit Rebate Amounts or Supplemental Unit Rebate Amounts.

The proceedings of each Pharmaceutical and Therapeutics Committee meeting or portion thereof that is open to the general public will be published.

16-004.04 Drug Utilization Review (DUR): The Department is authorized by federal statute to conduct a DUR program. The DUR program shall be in compliance with U.S.C., Title 42, Chapter 7, Subchapter XIX, Section 1396r – 8. The DUR program consists of prospective drug review, retrospective drug review, the application of explicit predetermined standards and an educational program. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary and that they are not likely to result in adverse medical results.

The Department or the Department’s contractor utilizes a DUR Board to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to them by the Department or the Department’s contractor(s) and, in concert with retrospective review of claims data, makes recommendations for educational interventions, prospective DUR and the prior authorization process. The DUR Director shall develop an agenda for each meeting and make it available to all interested parties at least 30 days before the meeting. The Department or the Department’s contractor may charge a reasonable fee for providing copies and mailing information to interested parties.

The Drug Use Review Board shall, upon the Department’s request, review drugs or classes of drugs and make recommendations to the Department regarding drugs or classes of drugs for prior authorization. The Department makes the final decision on which drugs or classes of drugs will require prior authorization.

For those drugs that will require prior authorization, the DUR Board shall develop and recommend prior authorization criteria to the Department. The Department may accept, reject, or modify the recommended criteria.

The Department will communicate information related to prior authorization criteria on the Department’s website. The DUR Board will review existing prior authorization criteria annually.
The manufacturer or any interested party may request that a drug or class of drugs on prior authorization be placed on the agenda of a DUR board meeting, but no drug or class of drugs will be placed on the DUR agenda more than once every 12 months without the consent of the DUR director, in consultation with the Department’s Pharmacy Consultant. The manufacturer of the drug may request that the DUR director waive the 30-day notification rule when asking to have its product placed on the agenda.

All DUR Committee meetings will be open to all interested parties. Public comments will be allowed, but may be constrained by necessity of time or other resources. The minutes of the proceedings of each DUR Committee meeting or portion thereof that is open to the general public will be published.

16-004.05 Pharmacy Services for clients residing in certain care facilities:

16-004.05A Non-Covered Items: NMAP does not cover the following items as pharmacy services for clients residing in a Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF/MR):

1. Hydrogen peroxide;
2. Rubbing alcohol; and
3. OTC enemas.

The NF or ICF/MR may be reimbursed for these items under the Department's payment plan for NF and ICF/MR services.

For clients residing in NFs and ICF/MRs, the Department does not cover medical supplies or durable medical equipment as pharmacy services. See 471 NAC 7-000.

16-004.05B Replacement Cost: Providers shall not duplicate medication, at the Department’s expense, for clients residing in facilities. The pharmacy or the facility is responsible for providing a replacement. Providers shall not bill the Department for medication that was destroyed upon a client’s discharge.

Examples of situations which are NOT to be billed to the Department include, but are not limited to, the following:

If the client's medication is:

1. Lost;
2. Broken;
3. Misplaced;
4. Not received by the facility;
5. Destroyed:
   a. During a client’s temporary absence from the facility (e.g., during therapeutic leave days, bedhold period, medical/surgical days);
   b. Following a change of directions; or
   c. At any time that the medication is ordered for the client, unless the medication has expired.
16-004.05C  Professional Dispensing Fees: Pharmacies providing medications to NF and ICF/MR patients are allowed one professional dispensing fee per recipient and drug per month.

16-004.05D  Unit Dose:

16-004.05D1  Definitions:

Traditional bottle method: Dispensing multiple tablets and capsules in one vial or bottle. This excludes systems such as cassettes, individually packaged doses on cards containing multiple doses and all similar systems.

Unit dose is a system of drug packaging, dispensing, returning, billing and crediting by a unit dose provider.

Unit dose packaging is drug packaging approved by the Nebraska Board of Pharmacy.

Unit dose dispensing is the provision to the patient of a 14-day or less supply of a drug in unit dose packaging.

Unit dose returning is the process of returning unit dose packaged drugs to the dispensing pharmacy.

Unit dose billing is billing the Department one time per calendar month for the quantity of drug used by the patient during the month (see 471 NAC 16-004.07E for exceptions). The quantity used is the difference between the quantity dispensed and the quantity returned. (Note: See 471 NAC 16-004.05B, Replacement Cost, for examples of drugs which are NOT considered to have been used by the patient and are NOT billable to the Department). The date of service for each unit dose billing shall be consistent from month to month.

Unit dose crediting is a process of issuing credits by the pharmacy to the Department for drugs accepted for return into inventory that were previously billed to and covered by the Department.

Unit dose provider is a pharmacy approved by the Department as a unit dose provider. Initial approval is contingent upon written agreement by the provider and demonstration by the provider, to the satisfaction of the Department, of the provider’s ability to use unit dose packaging, unit dose dispensing, unit dose returning, unit dose billing and unit dose crediting. Continuing approval is contingent upon the provider’s actual performance as specified in the written agreement.

16-004.05D2  Reimbursement: The Department shall only reimburse unit dose providers for prescribed drugs dispensed to Medicaid clients residing in facilities. A facility may submit a written request to the Department to waive the unit dose packaging requirements for clients participating in a rehabilitation program that includes training in medication management under the traditional bottle method. If a waiver is granted, the Department will notify the facility and the pharmacy of approval of the request.
16-004.05E  Drugs Returned for Credit: Providers that accept returns of dispensed drugs from long term care facilities shall credit the Department for those drugs. A drug cost level, below which credits shall not be mandatory, may be established by the Department.

16-004.06  Medical Supplies and Durable Medical Equipment: Any medical supply or durable medical equipment indicated as covered on the NE-POP System or on the Department’s web-site is covered as a pharmacy service under this chapter.

16-004.07 Quantity Limitations: The Department imposes the following quantity limitations on certain drugs.

16-004.07A  Payment from NMAP will not be approved for:
1) More than a 3 month supply of any maintenance medication.
2) More than a one month supply of any controlled substance.
3) More than a one month supply of any injectable medication except insulin and those injectable drugs with a duration of greater than one month from one dose.

16-004.07B  Quantities: The following types of limits may be utilized to ensure appropriate utilization and billing.
   a. Maximum quantity over time
   b. Maximum daily dose
   c. Maximum days supply per fill
   d. Maximum quantity per fill
   e. Minimum quantity per fill
   f. Maximum cost per fill
   g. Tablet splitting
   h. Number of units to require medication be submitted in multiples of the package size
16-004.07C  **Injections:** The Department applies the following limitations to injectable drug products:

1. Only those injections that are either self-administered by the client or are administered for the client at the client's place of residence are reimbursable. Injections that are administered by the provider or hospital are not reimbursable through the pharmacy services program (see 471 NAC 10-003.02 and 18-004.28);

2. Whenever available and the necessity warrants, multi-dose vials of medication shall be dispensed rather than single-dose vials or unit-dose syringes;

3. Single-dose syringes may be reimbursed at the proportionate cost of a multi-dose vial;

4. Maintenance injectable medications which are not reconstituted or admixed by the pharmacy prior to administration to the patient shall be dispensed and billed for the full month's supply;

5. Non-maintenance injectable medications and those injectable medications which must be reconstituted or admixed by the pharmacy prior to administration to the patient including subcutaneous, intramuscular, and intravenous medication delivery by large volume parenteral, piggyback, syringe pump or other methods may be provided at the pharmacist's discretion. Courses of therapy of ten days or less duration shall be billed at the end of the course of therapy. Courses of therapy of greater than ten days duration shall be billed at the end of the course of therapy or after each ten days of therapy; and

6. Injectable medications administered by implanted or similar devices may not be billed to the pharmacy services program when the device is filled in the clinic or hospital.

7. Total parenteral nutrition (TPN) shall be billed through the Durable Medical Equipment and Medical Supplies program. This includes the amino acids, carbohydrates, lipids and all additives. All TPN-compatible additives shall be billed through the supplier program regardless of who completes the addition of the ingredient or the method of administration.
16-004.07D Maintenance Drugs: The Department requires that any other maintenance drug or any drug used in a chronic manner be prescribed and dispensed in a minimum of a one-month supply.

Note: Providers shall not reduce prescriptions which are written for quantities larger than a month's supply to a month's supply. The Department considers prescription splitting to be fraudulent except when such reduction is done to comply with State or Federal regulations or statute.

16-004.07E Exceptions to Quantity Limitations: The Department allows the following exceptions to the quantity limitations of this subsection only for those clients that are receiving their medications by/through a non-unit-dose system, except where noted otherwise:

1. When the prescriber first introduces a maintenance drug to a patient's course of therapy, the prescriber may prescribe a smaller quantity as his/her judgment dictates. Pharmacists shall indicate that this is the initial filling of the medication when filing the drug claim. Any subsequent dispensing of this maintenance drug shall be prescribed and dispensed in at least a month's supply.

2. When the prescriber's professional judgment indicates that these quantities of medication are not in the patient's best medical interest, the prescriber may prescribe as his/her judgment directs. This includes limitations for lock-in clients. The pharmacist shall maintain documentation that an exception is being made to the Department's requirements.

3. The Department will consider replacement of any lost, misplaced, or stolen drug products for clients, only when the pharmacy provider or prescriber documents the conditions that require replacement. The Department will require additional information (police reports, etc.) prior to replacing controlled substances.

4. Schedule II drugs are exceptions to the quantity limitations. This also applies to unit dose systems, unless the Schedule II drug is used in a chronic or maintenance manner (e.g., methylphenidate for certain chronic conditions).

5. The Department will accept certain original shelf package sizes of medication, under the following conditions:
   a. An original shelf package of 480 ml, or less when not packaged in the pint size, is sufficient for the quantity limitations requirement for liquids. This also applies to unit dose systems;
   b. An original shelf package of 100 tablets or capsules, or less when not available in the 100 tablet or capsule size, for seldom-prescribed solid dosage drugs is sufficient for the quantity limitations requirement;
   c. Original shelf packages of 100 tablets or capsules of routinely prescribed drugs are not acceptable as sufficient for fulfillment of the quantity limitations requirement. The full month's supply shall be prescribed and dispensed; and
   d. Ready-made ointments, creams, etc., when used in a chronic or maintenance manner, may be dispensed in an original shelf package size provided the original size is closest to the needed amount of medication. This also applies to unit dose systems.
16-004.08 Utilization: Since it is the pharmacist’s professional responsibility to ascertain that drugs are being utilized according to the prescriber’s directions and that no abuse or overuse exists, the Department will not reimburse pharmacists for prescriptions which demonstrate a lack of this professional obligation. Providers are required to maintain patient record systems or other adequate records to prevent these errors in dispensing.

The Department’s professional staff is responsible for determining whether a claim violates the Department’s regulations.

The NE-Pop system will identify drug claims when potential overuse exists; these claims will be denied.

16-004.09 Tobacco Cessation: Medicaid covers tobacco cessation services as practitioner and pharmacy services under the following conditions:

1. Up to two tobacco cessation sessions may be covered in a 12-month period. A session is defined as medical encounters and drug products as listed in items 2 and 3 below. Client access to the Nebraska Tobacco Free Quitline will be unlimited.

2. Practitioner Office Visits:
   a. Clients shall see their medical care provider (physician/mid-level practitioner) for evaluation particularly for any contraindications for drug products and to obtain prescription(s) if tobacco cessation products are needed.
   b. (1) In addition to the evaluation under item 2a, a total of four tobacco cessation counseling visits with a medical care provider or tobacco cessation counselor (see 471 NAC 16-002.04) are covered for each tobacco cessation session. This may be a combination of intermediate or intensive tobacco cessation counseling visits.
      (2) Tobacco cessation counseling provided by a Tobacco Cessation counselor shall be ordered by the physician/mid-level practitioner.

3. Tobacco cessation products are covered by Medicaid as a pharmacy service (see 471 NAC 16-000) for those clients 18 years of age or older who require that particular assistance.
   a. Coverage of products used for tobacco cessation is limited to a maximum 90 days supply in one tobacco cessation session. Up to two 90 day supplies may be covered in a 12 month period, beginning with the date the first prescription for the products is dispensed.
   b. Tobacco cessation products will only be covered when clients are currently enrolled with and actively participating in the Nebraska Tobacco Free Quitline. Disenrollment or lack of active participation in the Nebraska Tobacco Free Quitline will result in discontinuation of Medicaid coverage of tobacco cessation drug products.

4. Nebraska Tobacco Free Quitline: For coverage of tobacco cessation products, clients shall be enrolled in and active with the Nebraska Tobacco Free Quitline. Referral to the Quitline may be made by a medical professional (physician/mid-level practitioner) or a self referral.
16-005 Payment for Pharmacy Services

16-005.01 Professional Dispensing Fees

16-005.01A: A professional dispensing fee of $10.02 will be assigned to each claim payment based on the lesser of methodology described below.

16-005.01B Dispensing Physicians: The Department assigns a professional dispensing fee to a dispensing physician only when there is no pharmacy within a 25-mile radius of the physician's place of practice.

16-005.02 Reimbursement Methodology

Note: Payment levels for all drugs will not exceed, in the aggregate, upper levels of reimbursement established by federal law.

16-005.02A Brand Necessary Certification of Drugs: The Federal Upper Limit (FUL) or State Maximum Allowable Cost (SMAC) limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the usual and customary charge or National Average Drug Acquisition Cost (NADAC) will be the maximum allowable cost. The prescriber must certify on Form MC-6 that a brand name is medically necessary.

16-005.02A1 Completion of Form MC-6: The Department requires completion of the prescriber certification form to meet federal requirements:

1. Form MC-6 will contain the handwritten signature of the prescriber. Rubber stamp signatures and initials are not acceptable;
2. A separate Form MC-6 is required for each drug product;
3. Form MC-6 will be submitted to the Department or the Department's designated contractor;
4. Notice of approval or denial will be returned to the dispensing pharmacy via fax. Copies are to be retained by the dispensing pharmacy and serve as proof of certification;
5. The original and subsequent prescriptions will contain designation consistent with Nebraska pharmacy practice law noting drug product selection is not permitted; and
6. The prescriber will certify the effective period (From and To) dates on Form MC-6. The duration will not exceed one year. A new Form MC-6 is required when the effective dates of the certification expire.

16-005.03 Pricing Instructions: Pharmacists will not, under any circumstances, submit charges to the Department which exceed the pharmacy's usual and customary charge.

16-005.03A Pricing: Any loss leader prices, shelf prices, sale prices, cash only prices, coupon certificates, newspaper or brochure ad prices that are in effect on the date the prescription is dispensed will be considered the pharmacy's usual and customary charge to the general public.
16-005.03B Price Matching: When a pharmacy lowers its usual and customary price for a prescription (for example: to match a competitor's price), all claims submitted to Medicaid for the same drug and quantity dispensed during that business day will also be billed at the lowered price.

16-005.04 Payment Methodology

16-005.04A Legend, Non-legend Drugs and Compounded Prescriptions: The Nebraska Medicaid Drug Program is required to reimburse ingredient cost for covered outpatient legend and non-legend drugs at the lowest of:

a. The usual and customary charge to the public;
b. The National Average Drug Acquisition Cost (NADAC), plus the established professional dispensing fee;
c. The Affordable Care Act (ACA) Federal Upper Limit (FUL), plus the established professional dispensing fee; or
d. The calculated State Maximum Allowable Cost (SMAC), plus the established professional dispensing fee.

Backup Ingredient Cost Benchmark
If National Average Drug Acquisition Cost (NADAC) is not available, the allowed ingredient cost will be the lesser of Wholesale Acquisition Cost (WAC) + 0%, State Maximum Allowable Cost (SMAC) or the Affordable Care Act (ACA) Federal Upper Limit (FUL), plus the established professional dispensing fee.

Specialty Drugs
Specialty drugs will be reimbursed at National Average Drug Acquisition Cost (NADAC). If National Average Drug Acquisition Cost (NADAC) is not available, then the Backup Ingredient Cost Benchmark will apply.

340B Drug Pricing Program
Covered legend and non-legend drugs, including specialty drugs, purchased through the Federal Public Health Service’s 340B Drug Pricing Program (340B) by covered entities that carve Medicaid into the 340B Drug Pricing Program, will be reimbursed at the 340B actual acquisition cost, but no more than the 340B ceiling price, plus the established professional dispensing fee.

A 340B contract pharmacy under contract with a 340B covered entity described in section 1927 (a)(5)(B) of the Act is not covered.

Federal Supply Schedule (FSS)
Facilities purchasing drugs through the Federal Supply Schedule (FSS) will be reimbursed at no more than their actual acquisition cost, plus the established professional dispensing fee.
Clotting Factor

a. Pharmacies dispensing Antihemophilic Factor products will be reimbursed at the lesser of methodology, plus the established professional dispensing fee. If National Average Drug Acquisition Cost (NADAC) is not available, the lesser of methodology for the allowed ingredient cost will be the Wholesale Acquisition Cost (WAC) + 0%, the Average Sales Prices (ASP) + 6%, or the Affordable Care Act (ACA) Federal Upper Limit (FUL); and

b. Pharmacies dispensing Antihemophilic Factor products purchased through the Federal Public Health Service’s 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program will be reimbursed at the 340B actual acquisition cost, but no more than the 340B ceiling price, plus the established professional dispensing fee.

Drugs Purchased at Nominal Price

Facilities purchasing drugs at Nominal Price (outside of Federal Public Health Service’s 340B Drug Pricing Program [340B] or Federal Supply Schedule [FSS]) will be reimbursed by their actual acquisition cost, plus the established professional dispensing fees.

Investigational Drugs
Excluded from coverage.

Tribal Rates
Tribal pharmacies will be paid the federal encounter rate.

Certified Long-Term Care
Pharmacies providing covered outpatient prescription services for Certified Long-Term Care beneficiaries will be reimbursed for ingredient cost using the lesser of methodology, plus the established professional dispensing fee.

16-005.04B Unit Dose Prescriptions: The Department defines unit dose at 471 NAC 16-004.05D. Unit dose providers are allowed one professional dispensing fee per recipient and drug per month. For exceptions to the one professional dispensing fee per recipient and drug per month, see 471 NAC 16-004.07E.

16-005.04C Sales Tax: The State of Nebraska is tax exempt; therefore, providers do not charge sales tax on claims to the Department.

16-005.05 Third Party Liability: The pharmacy provider will bill any third party resource for claims before billing Medicaid. All third party resources available to Medicaid clients shall be utilized for all or part of their medical costs before Medicaid. Third party resources are any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any medical services furnished to a client. See 471 NAC 3-004.

16-006 Billing Requirements

16-006.01 Drug Claims: Claims for pharmacy services shall meet the requirements listed in the NE-POP System user's manual. The same standards apply to non-NE-POP system claims.
16-006.02 Medical Supplies and Durable Medical Equipment Claims: Providers shall bill electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) or Form CMS-1500, "Health Insurance Claim Form," (see 471-000-55) to submit claims for medical supplies and durable medical equipment unless otherwise stipulated. See 471 NAC 7-000 on durable medical equipment and medical supplies.

16-006.03 Electronic Media Claim (EMC) Requirements: While the Department utilizes the NE-POP System, providers are responsible for any errors, omissions, or inappropriate billings submitted by themselves or on their behalf by billing agents. The submission of any EMC for reimbursement by the provider or by an approved company or organization on behalf of an approved provider constitutes certification that -

1. The services or items for which payment is claimed were provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973;
2. The amounts claimed are in accordance with the Department's regulations, and no additional charge (other than Medicaid copayment) has been or will be claimed;
3. Each service is documented and the documentation is open to audit by the Department or its agents; and
4. The charge does not exceed the pharmacy's usual and customary charge to the general public.
CHAPTER 17-000 PHYSICAL THERAPY SERVICES

17-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), the physical therapist must be licensed by the Nebraska Department of Health and Human Services. If services are provided outside Nebraska, the qualified physical therapist must be:

1. A graduate of a program of physical therapy approved by both the committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; or
2. Where applicable, licensed by the State.

17-001.01 Certified Physical Therapy Assistant: NMAP does not enroll certified physical therapy assistants (PTA) as providers. Services provided by a PTA are billable to NMAP when all requirements of 172 NAC 137 are met.

If services are provided outside Nebraska, the supervising physical therapy provider must submit a photocopy of the PTA’s state certificate. The supervising physical therapist will be notified by the Department of Health and Human Services, Division of Medicaid and Long Term Care if services provided by the PTA are not billable to NMAP.

17-001.02 Provider Agreement: The physical therapist must complete and sign Form MC-19, “Medical Assistance Provider Agreement,” (see 471-000-90) and submit it to the Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care to be approved for provider enrollment.

17-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

17-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider must provide services only under arrangement with the HMO.

17-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. The client's primary care physician (PCP) in the PCCM must refer the client for physical therapy services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.
17-003 Covered Services: NMAP covers physical therapy services when the following criteria are met:

1. The services are ordered by a licensed physician;
2. The services are medically necessary;
3. The services are of such a level of complexity and sophistication or the condition of the patient is such that only a licensed physical therapist can safely, and effectively perform the service; and
4. The physical therapy service meets at least one of the conditions listed in 471 NAC 17-003.01 or 17-003.02.

17-003.01 Services for Individuals Age 21 and Older: NMAP covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy and speech therapy). The services must be:

1. An evaluation; or
2. Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time; or
3. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

17-003.02 Services for Individuals Age 20 and Younger: NMAP covers physical therapy services for individual birth to age 20 when the following criteria are met. The service must be:

1. An evaluation;
2. Reasonable and medically necessary for the treatment of the client’s illness or injury; or
3. Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time; or
4. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.
17-003.03 Maintenance Therapy: NMAP does not cover maintenance therapy provided by a physical therapist. The physical therapist must:

1. Evaluate the client's needs;
2. Design a maintenance program; and
3. Instruct the client, family members, or nursing facility staff in carrying out the program.

17-003.04 Orthotic Appliances and Devices: NMAP covers orthotic appliances and devices when medically necessary for the client's condition, and when the orthotic appliance or device is applied or used during the therapy session.

17-003.05 Supplies: NMAP will consider payment for certain supplies that are used during the course of treatment and require application by the physical therapist except those supplies that are considered incident to the procedure provided.

17-004 Non-Covered Physical Therapy Services: NMAP does not cover physical therapy in the following situations:

1. Clients Age 21 and Older – therapy sessions in excess of 60 sessions per fiscal year for any combination of physical therapy, occupational therapy and speech therapy;
2. Therapy for work hardening, or vocational and prevocational assessment and training;
3. Therapy for functional capacity evaluations, educational testing, drivers training, or training in non-essential self-help or recreational activities (e.g. homemaking, cooking, finance), training related to learning disability, attention disorder, visual perception training, or treatment of psychological conditions;
4. In-service training for nursing facility staff which is not client specific. (These services may be allowed under nursing facility reimbursement as a consulting service.);
5. Rental of equipment; or
6. Take home supplies.

17-005 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of “Treatment Services” in 471 NAC 33-001.04. These services must be prior authorized by the Division of Medicaid and Long-Term Care.

17-006 Payment for Physical Therapy Services

17-006.01 Individual Providers: The Nebraska Medical Assistance Program pays for covered physical therapy services at the lower of:
1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Division of Medicaid and Long-Term Care (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-517).

17-006.01A Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Division of Medicaid and Long-Term Care determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of the revisions and their effective dates.

17-006.02 Hospitals: For payment as a hospital service see 471 NAC 10-000, Hospital Services.

17-006.03 Home Health Agencies: For payment as a home health agency service, see 471 NAC 9-000, Home Health Agencies.

17-007 Billing Requirements

17-007.01 Medicare or Other Insurance Coverage: If the client is eligible for Medicare or has other insurance which may cover physical therapy, the provider must bill the Medicare carrier or the insurance company before submitting a claim to the Department.

17-007.02 Medical Necessity Documentation: The provider must provide the following information when submitting a claim for physical therapy services:

1. Date of illness/injury onset.
2. Date physical therapy plan established.
3. Date physical therapy started.
4. Number of physical therapy visits from onset.
17-007.03 Utilization Review: Claims for physical therapy services are subject to utilization review by the Department to determine medical necessity and appropriateness of the service.

17-007.04 Required Forms and Standard Electronic Transactions: Depending on the place of service, the provider must use the forms and transactions required by NMAP as follows:

1. If the service is provided at the patient's home or the therapist's office, the provider must claim payment on Form CMS-1500 (see 471-000-61) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The provider must use the appropriate place of service code and CPT or HCPCS codes on the claim;
2. If the service is provided in a hospital, inpatient or outpatient setting, the hospital submits claims to NMAP for physical therapy services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837); and
3. If the service is provided by a home health agency, the agency must claim payment on Form CMS-1450 (see 471-000-57) or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

The provider or the provider's authorized agent must enter the provider's usual and customary charge for each procedure code listed on or in the claim.

17-007.05 Procedure Codes: Individual providers billing on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) must use the American Medical Association's Current Procedural Terminology (CPT) or HCPCS procedure codes when billing NMAP.

Hospital providers billing on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) must use the appropriate revenue codes when billing NMAP.

Home health agencies billing on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) must use the procedure codes listed in 471-000-57.
CHAPTER 18-000 PHYSICIANS' SERVICES

18-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), physicians, including osteopaths, must be licensed at the time the service is provided by the Nebraska Department of Health and Human Services, Division of Public Health, or its equivalent in another state.

18-001.01 Provider Agreement: The physician or the physician’s authorized agent must complete and sign Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90). The provider submits Form MC-19 to the Department for approval of the provider enrollment. Providers not meeting the conditions of the provider agreement are not eligible for participation in NMAP.

18-001.02 Independent Clinical Laboratories: In addition to the provider agreement, independent clinical laboratories must meet the following requirements:

1. When state or applicable local law requires licensing of independent clinical laboratories, the laboratory must be licensed under the law; and
2. The laboratory must meet the health or safety requirements of the Department of Health and Human Services (HHS).

For a Nebraska independent lab to be an approved provider under NMAP, the Division of Medicaid and Long-Term Care must receive a copy of Form CMS-1539, "Medicaid/Medicare Certification and Transmittal," (see 471-000-66) which displays current Medicare certification from the CMS Regional Office. The CMS Regional Office updates certification information and sends the information to the Division according to the federal time frame which is currently in effect for independent clinical laboratory surveys. For an out-of-state independent clinical lab to be an approved provider under NMAP, the Division must request verification of certification from the CMS Regional Office. The Division approves or denies enrollment based on the certification information received from the CMS Regional Office.
18-002 Covered Services: NMAP covers medically necessary physicians’ services within program guidelines which are provided -

1. Within the scope of the practice of medicine or osteopathy as defined by Nebraska state law; and
2. By, or under the personal supervision of, an individual licensed under Nebraska law to practice medicine or osteopathy.

Physicians’ services may be provided at the physician’s office, the client's home, a hospital, a long term care facility, or elsewhere.

18-002.01 Facility Based Physician Clinics: Physician Clinic services provided in a hospital location or a facility under the hospital’s licensure are considered content of the physician service, not outpatient hospital services. Physician clinic services are defined as the professional activity, any drugs and supplies used during that professional encounter and any other billable service provided in the physician clinic area.

1. Nebraska Medicaid does not recognize facility/hospital based non-emergency physician clinics for billing, reimbursement or cost reporting purposes except for itinerant physicians as defined in 471 NAC 18-004.41/10-005.21.
2. Services and supplies incident to a physician’s professional service provided during a specific encounter are covered and reimbursed as physician clinic services if the service or supply is:
   a. Of the type commonly furnished in a physician’s office;
   b. Furnished as an incidental, although integral, part of the physician professional service; and
   c. Furnished under the direct personal supervision of the physician.
3. The Physician’s clinic services must be billed to the Medicaid Program on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

18-002.02 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 6 listed in the definition of "Treatment Services" in 471 NAC 33-001.03. These services must be prior authorized by the Division of Medicaid and Long-Term Care.
18-003 Non-Covered Services

18-003.01 Surgical Procedures: NMAP does not cover -

1. Acupuncture;
2. Angiocardiology, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
3. Angiocardiology, utilizing CO₂ method, supervision and interpretation only;
4. Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
5. Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
6. Ballistocardiogram;
7. Basal metabolic rate (BMR);
8. Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
9. Circumcision, female;
10. Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
11. Extra-intra cranial arterial bypass for stroke;
12. Fabric wrapping of abdominal aneurysm;
13. Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
14. Fascia lata by stripper when used as a treatment for lower back pain;
15. Hypogastric or presacral neurectomy (independent procedure);
16. Hysterotomy, non-obstetrical, vaginal;
17. Icterus index;
18. Ileal bypass or any other intestinal surgery for the treatment of obesity; and
19. Kidney decapsulation, unilateral and bilateral;
20. Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebitic syndrome;
21. Ligation of internal mammary arteries, unilateral or bilateral;
22. Ligation of thyroid arteries (independent procedure);
23. Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;
24. Omentopexy for establishing collateral circulation in portal obstruction;
25. Perirenal insufflation;
26. Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
27. Protein bound iodine (PBI);
28. Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
29. Reversal of tubal ligation or vasectomy;
30. Sex change procedures;
31. Splanchicectomy, unilateral or bilateral, when used as a treatment for hypertension;
32. Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both;
33. Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension;
34. Uterine suspension, with or without presacral sympathectomy.

18-003.02 Obsolete Tests: NMAP does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:

1. Amylase, blood isoenzymes, electrophoretic;
2. Chromium, blood;
3. Guanase, blood;
4. Zinc sulphate turbidity, blood;
5. Skin test, cat scratch fever;
6. Skin test, lymphopathia venereum;
7. Circulation time, one test;
8. Cephalin flocculation;
9. Congo red, blood;
10. Hormones, adrenocorticotropin quantitative animal tests;
11. Hormones, adrenocorticotropin quantitative bioassay;
12. Thymol turbidity, blood;
13. Skin test, actinomycosis;
14. Skin test, brucellosis;
15. Skin test, leptospirosis;
16. Skin test, psittacosis;
17. Skin test, trichinosis;
18. Calcium, feces, 24-hour quantitative;
19. Starch; feces, screening;
20. Chymotrypsin, duodenal contents;
21. Gastric analysis pepsin;
22. Gastric analysis, tubeless;
23. Calcium saturation clotting time;
24. Capillary fragility test (Rumpel-Leede);
25. Colloidal gold;
26. Bendien's test for cancer and tuberculosis;
27. Bolen's test for cancer; and

These tests may be covered only if the physician who performs or orders the test justifies the medical necessity for it. The justification must be submitted with the claim when submitted to NMAP. Staff in the Medicaid Division determine that satisfactory medical necessity exists from the physician's justification.
18-003.03 Services Required to Treat Complications or Conditions Resulting from Non-Covered Services: NMAP may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

Medical inpatient or outpatient hospital services are sometimes required to treat a condition that arises from services which NMAP does not cover, e.g., cosmetic surgery which is excluded from Medicaid coverage by statute. Payment may be made for services furnished under these circumstances if they are reasonable and necessary in all other respects. Examples of services that may be found to be covered under this policy are the repair of complications from transsexual surgery, repair of complications from cosmetic surgery, and removal of a non-covered bladder stimulator.

If the services in question are determined to be part of a previous non-covered service, i.e., an extension or a periodic segment of a non-covered service or followup care associated with it, the subsequent services will be denied. For example, when a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's prognosis, these visits are not covered.

18-003.04 Services Not Reasonable and Necessary: NMAP does not cover items and services which are not reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the function of a malformed body member.

18-003.05 Surgical Assistant Fees: NMAP does not cover surgical assistance fees for

1. Laparoscopy, including laparoscopic tubal ligation;
2. Tonsillectomy, adenoidectomy, myringotomy;
3. Conservative or closed fracture care; and
4. Uncomplicated procedures of the integument.

Additional assistant fees may be determined to be noncovered during the utilization review process.

18-003.06 Endometrial Aspiration: NMAP does not cover vacutage type or other endometrial aspiration or curettage unless the provider submits the pathologist's report on the tissue with all claims for this service. For diagnoses of absent, delayed, or late menstruation, the physician shall administer a pregnancy test to determine that the client is not pregnant. When requested, the provider shall submit copies of clients' medical records to NMAP. Reimbursement must be withheld or refunded if NMAP does not receive the requested documentation. A non-pregnant diagnosis must be indicated on Form CMS-1500, "Health Insurance Claim Form," (see 471-000-62) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) before NMAP can make payment for these procedures.
18-004 Limitations and Requirements for Certain Services

18-004.01 Prior Authorization: NMAP requires that physicians request prior authorization from the Medicaid Division before providing:

1. Medical transplants, as follows:
   a. Heart transplants;
   b. Kidney transplants;
   c. Bone marrow transplants (allogenic and autologous); and
   d. Liver transplants;
2. Abortions;
3. Cosmetic and reconstructive surgery;
4. Gastric bypass surgery for obesity which includes the following procedures:
   a. Gastric bypass;
   b. Gastric stapling; and
   c. Vertical banded gastroplasty;
5. Out-of-State services (Exception: Prior authorization is not required for emergency services);
6. Established procedures of questionable current usefulness;
7. Procedures which tend to be redundant when performed in combination with other procedures;
8. New procedures of unproven value;
9. Certain drug products, as specified in 471 NAC 18-004.25C and 18-004.25C1; and
10. All non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans. See 471 NAC 18-004.30A.

18-004.01A Prior Authorization Procedures: The physician must request prior authorization for these services in writing or electronically using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instruction at 471-000-50) prior to providing the service.

18-004.01A1 Request for Additional Evaluations: NMAP shall request additional evaluations when the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

18-004.01A2 Prior Authorization Approval/Denial Process: The prior authorization request review and determination must be completed by one or all of the following Department representatives:

1. Medical Director;
2. Designated Department Program Specialists; and
3. Medical Consultants for the Department for certain specialties.
18-004.01A3 Notification Process: Upon determination of approval or denial, the Department shall send a written notification to the following as applicable to the request:

1. Physician(s) submitting or contributing to the request; and
2. Caseworker when appropriate.

18-004.01B Verbal Authorization Procedures: NMAP may issue a verbal authorization when circumstances are of an emergency nature or urgent to the extent that a delay would place the client at risk of receiving medical care. When a verbal authorization is granted, a written request or electronic request using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) must be submitted within 14 days of the verbal authorization. A written or electronic response from the Department will be issued upon completion of the review.

18-004.01C Billing and Payment Requirements: Claims submitted to NMAP for services defined as requiring prior authorization will not be paid without approval from the Department. A copy of the approval documentation issued by the Department is not needed for submission with the claim unless instructed to do so as part of the authorization notification.

18-004.02 Hospital Admission Diagnostic Procedures: The major factors which are considered to determine that a diagnostic procedure performed as part of the admitting procedure to a hospital is reasonable and medically necessary are -

1. The test is specifically ordered by the admitting physician, or a hospital staff physician responsible for the patient when there is no admitting physician (i.e., the test is not provided on the standing orders of a physician for all his/her patients);
2. The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and
3. The test does not unnecessarily duplicate the same test performed on an outpatient basis before admission or performed in connection with a recent hospital admission.

18-004.03 Minor Surgical Procedures: Reimbursement for excision of lesions of the skin or subcutaneous tissues include all services and supplies necessary to provide the service. NMAP does not make additional reimbursement for suture removal to the physician who performed the initial services or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the physician who provided the initial service, NMAP may approve separate payment for the suture removal.

18-004.04 Treatment for Obesity: NMAP will not make payment for services provided when the sole diagnosis is "obesity".

Obesity itself cannot be considered an illness. The immediate cause is a caloric intake which is persistently higher than caloric output. When obesity is the only diagnosis, treatment cannot be considered reasonable and necessary for the diagnosis or treatment of an illness or injury.
While obesity is not itself considered an illness, there are conditions which can be caused by or aggravated by obesity. This may include, but is not limited to the following: hypothyroidism, Cushing's disease, hypothalamic lesions, cardiac diseases, respiratory diseases, diabetes, hypertension, and diseases of the skeletal system. Treatment for obesity may be covered when the services are an integral and necessary part of a course of treatment for another serious medical condition.

18-004.04A Intestinal By-Pass Surgery: The safety of intestinal by-pass surgery for the treatment of obesity has not been demonstrated. Severe adverse reactions such as steatorrhea, electrolyte depletion, liver failure, arthralgia, hypoplasia of bone marrow, and avitaminosis have sometimes occurred as a result of this procedure. NMAP does not consider this procedure to be reasonable and necessary, and does not cover the procedure.

18-004.04B Gastric By-Pass Surgery for Obesity: Gastric by-pass surgery for patients with extreme obesity may be covered when the surgery is -

1. Medically appropriate for the individual; and
2. Performed to correct an illness which caused the obesity or was aggravated by the obesity.

Physicians shall request prior authorization for gastric by-pass surgery prior to providing the service.

18-004.05 Breast Reconstruction Following Mastectomy: Because breast reconstruction following mastectomy is considered a relatively safe and effective noncosmetic procedure, NMAP may cover this service following initial treatment.

18-004.06 Sterilizations

18-004.06A Age Requirement: The Nebraska Medical Assistance Program is prohibited from paying for sterilization of individuals -

1. Under the age of 21 on the date the client signs Form MMS-100; or
2. Legally incapable of consenting to sterilization.

18-004.06B Coverage Conditions: NMAP covers sterilizations only when -

1. The sterilization is performed because the client receiving the service made a voluntary request for services;
2. The client is advised at the outset and before the request or receipt of his/her consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized; and
3. Clients whose primary language is other than English must be provided with the required elements for informed consent in their primary language.
18-004.06C Procedure for Obtaining Services: Non-therapeutic sterilizations are covered by NMAP only when -

1. Legally effective informed consent is obtained on Form MMS-100, "Consent Form" (see 471-000-109) from the client on whom the sterilization is to be performed. A properly completed and legible Form MMS-100 must submitted to the Department before payment of claims for sterilization can be considered; and

2. The sterilization is performed at least 30 days following the date informed consent was given. The consent is effective for 180 days from the date the client signs Form MMS-100. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since s/he signed the informed consent for the sterilization. For a premature delivery, the client must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MMS-100.

18-004.06D Informed Consent: Informed consent means the voluntary, knowing assent of the client who is to be sterilized after s/he has been given the following information:

1. A clear explanation of the procedures to be followed;
2. A description of the attendant discomforts and risks;
3. A description of the benefits to be expected;
4. Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;
5. An offer to answer any questions concerning the procedures; and
6. An instruction that the individual is free to withhold or withdraw his/her consent to the sterilization at any time before the sterilization without prejudicing his/her future care and without loss of other project or program benefits to which the client might otherwise be entitled.

This information is shown on Form MMS-100, which must be completed by the client.

18-004.06E Sterilization Consent Forms: Form MMS-100, "Sterilization Consent Form," (see 471-000-109) may be ordered by the physician directly from the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, or from the client's local office. The surgeon must submit a properly completed and legible Form MMS-100 to the Department before payment can be considered for the sterilization.
18-004.07 Hysterectomies: Form MMS-101, "Informed Consent Form," (see 471-000-110) in which the client states that she was informed before the surgery was performed that this surgical procedure will result in permanent sterility must be properly signed and dated by the client. The completed Form MMS101 must be submitted to the Department of Health and Human Services, by the surgeon before claims for the hysterectomy can be considered for payment.

Exception: NMAP does not require informed consent if -

1. The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was already sterile before the hysterectomy and states the cause of the sterility; or
2. The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which s/he determined prior acknowledgment was not possible. The physician must also include a description of the emergency.

A copy of the surgeon’s certification regarding the above exceptions must be submitted to NMAP before consideration of payment for associated with the hysterectomy.

18-004.07A Non-Covered Hysterectomies: NMAP shall not cover a hysterectomy if -

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

18-004.08 (Reserved)

18-004.09 Infertility: NMAP limits coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical problem, for example, thyroid disease, brain tumor, or hormone dysfunction. Reimbursement/coverage is not available when the sole purpose of the service is achieving a pregnancy.

18-004.10 (Reserved)

18-004.11 Alcohol and Drug Detoxification: NMAP limits reimbursement for alcohol and drug detoxification to medically necessary treatment for detoxification, subject to the Department’s utilization review.

Many hospitals provide detoxification services during the more acute stages of alcohol and drug dependency when the patient may be suffering from delirium, confusion, trauma, unconsciousness, and is no longer able to socially function. Since the high probability and occurrency of medical complications during alcohol and drug withdrawal can necessitate the constant availability of physicians and/or complex medical equipment found only in the hospital setting, inpatient hospital care during the period is considered reasonable and necessary and is therefore covered under the program.
This period includes an average detoxification period of two to three days with an occasional need for up to five days when the patient’s condition dictates. A detoxification program for a particular patient may exceed five days and be covered if determined medically necessary by NMAP. NMAP does not cover services when the detoxification needs of an individual no longer require an inpatient hospital setting.

18-004.12 Osteogenic Stimulation: Electrical stimulation to augment bone repair (osteogenic stimulation) can be performed either invasively or noninvasively.

18-004.12A Invasive Osteogenic Stimulation: Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. For percutaneously placed cathodes, the power supply is externally placed and the leads connected to the inserted cathodes. For the implanted cathode, the power pack is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. NMAP covers use of the invasive device only for non-union of long bone fractures. NMAP considers non-union to exist only after six months or more have elapsed without the fracture healing.

18-004.12B Non-Invasive Osteogenic Stimulation: For non-invasive device, opposing pads wired to an external power supply are placed over the cast. An electromagnetic field is created between the pads at the fracture site. NMAP covers use of the non-invasive device only for -

1. Non-union of long bone fractures;
2. Failed fusion; and
3. Congenital pseudoarthroses.
18-004.13  **Biofeedback Therapy**: Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Biofeedback therapy differs from electromyography, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. An electromyography device may be used to provide feedback with certain types of biofeedback, however.

Biofeedback therapy is covered under NMAP only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states, for psychosomatic conditions, or for psychiatric conditions.

18-004.14  **Sleep Disorder Clinics**: Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. These clinics are primarily for research. Nevertheless, sleep disorder clinics may provide some diagnostic or therapeutic services which NMAP covers. These clinics must be affiliated with a hospital. Coverage for diagnostic services would under some circumstances be covered under provisions of the law different from those for coverage of therapeutic services.

18-004.14A  **Diagnostic Services**: All reasonable and necessary diagnostic tests given for the medical conditions listed in 471 NAC 18-004.14B are covered when the following criteria are met:

1. The clinic must be affiliated with a hospital;
2. Patients must be referred to the sleep disorder clinic by their attending physicians. The clinic shall maintain a record of the attending physician's orders; and
3. The need for diagnostic testing must be confirmed by medical evidence, e.g., physician examinations and laboratory tests.

Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered.
18-004.14B Medical Conditions for which Diagnostic Testing is Covered: Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the following conditions. Most patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over. The overnight stay is considered an integral part of these tests.

1. Narcolepsy: This term refers to a syndrome that is characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep. Related diagnostic testing is covered if the patient has inappropriate sleep episodes or attacks (e.g., while driving, in the middle of a meal, in the middle of a conversation), amnesiac episodes, or continuous disability drowsiness. The sleep disorder clinic shall submit documentation that this condition is severe enough to interfere with the patient's well-being and health before Medicaid benefits may be provided for diagnostic testing. A maximum of three "sleep naps" to confirm a diagnosis of narcolepsy may be covered.

2. Sleep Apnea: This is a potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described - central, obstructive, and mixed. The nature of the apnea episodes can be documented by appropriate diagnostic testing. A maximum of one night stay per patient may be allowed.

18-004.14C Therapeutic Services: Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Although only the diagnostic services indicated above are covered under Medicaid, therapeutic services may be covered provided they are standard and accepted services and are reasonable and medically necessary for the patient. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services may be provided for -

1. Insomnia;
2. Nocturnal myoclonus (muscle jerks);
3. Sleep apnea (typically central type);
4. Drug dependency;
5. Shift work and schedule disturbances;
6. Restless leg syndrome;
7. Hypersomnia (excessive daytime sleepiness);
8. Somnambulism;
9. Night terrors or dream anxiety attacks;
10. Enuresis; and

18-004.15 Portable X-Ray Services: NMAP covers diagnostic x-ray services provided by certified a portable x-ray supplier when provided in a place of residence used as the patient's home and in nonparticipating institutions. These services must be performed under the general supervision of a physician and certain conditions relating to health and safety (see 471 NAC 18-004.15B) must be met.

NMAP also covers diagnostic portable x-ray services when provided in participating SNF's, under circumstances in which they cannot be covered as a SNF service, i.e., the services are not provided by the participating institution either directly or under arrangements that allow the institution to bill for the services.

If portable x-ray services are provided in a participating hospital under arrangement, the hospital shall bill for the service.

18-004.15A Certified Providers: To be approved as a provider under NMAP, providers of portable x-ray services must be certified by the CMS Regional Office.

For a Nebraska portable x-ray provider, NMAP must receive a copy of Form CMS-1539, "Medicare/Medicaid Certification and Transmittal," which displays Medicare certification from the CMS Regional Office.

For an out-of-state portable x-ray provider, Medicaid Division staff shall request verification of certification from the CMS Regional Office. The Department approves or denies enrollment based on the certification information received from the CMS Regional Office.

The CMS Regional Office updates certification information and sends the information to the Department according to the federal time frame which is currently in effect for portable x-ray providers.

18-004.15B Applicability of Health and Safety Standards: The health and safety standards apply to all suppliers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services. Payment is made only for services of approved suppliers who have been found to meet the standards.
When the services of a supplier of portable x-ray services no longer meet the conditions of coverage, physicians responsible for supervising the portable x-ray services and having an interest in the supplier's certification status must be notified. The notification action regarding suppliers of portable x-ray equipment is the same as required for decertification of independent laboratories, and the same procedures are followed.

18-004.15C Covered Portable X-Ray Services: NMAP covers the following portable x-ray services:

1. Skeletal films involving arms and legs, pelvis, vertebral column, and skull;
2. Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations); and
3. Abdominal films which do not involve the use of contrast media.

18-004.15D Non-Covered Portable X-Ray Services: NMAP does not cover the following portable x-ray services:

1. Procedures involving fluoroscopy;
2. Procedures involving the use of contrast media;
3. Procedures requiring the administration of a substance to the patient or injection of a substance into the patient and/or special manipulation of the patient;
4. Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
5. Procedures requiring special technical competency and/or special equipment or materials;
6. Routine screening procedures; and
7. Procedures which are not of a diagnostic nature.

18-004.15E Billing Requirements: Claims for portable x-ray services must contain -

1. The name of the physician who ordered the service; and

18-004.15F Electrocardiograms: The taking of an electrocardiogram tracing by an approved provider of portable x-ray services may be covered as an "other diagnostic test." The health and safety standards in 471 NAC 18-004.15B must be met.

18-004.16 Durable Medical Equipment and Supplies: NMAP does not generally enroll hospitals, hospital pharmacies, long term care facilities, rehabilitation services or centers, or physicians as providers of durable medical equipment and medical supplies.
18-004.17 Surgery: The surgical procedure, including 14 days post-operative care, is reimbursed under a HCPCS surgery procedure code. When multiple surgical procedures are done at one time, the Department reimburses the primary procedure according to the Nebraska Medicaid Practitioner Fee Schedule. Any secondary procedures that add significant time and complexity to patient care are reimbursed at one-half of the amount that would be paid if the procedure were the primary procedure. Incidental procedures through the same incision (for example, incidental appendectomy, lysis of adhesions, excision of a previous scar, puncture of an ovarian cyst) are not considered separate secondary procedures for reimbursement.

18-004.17A Assistant Surgeon: When an assistant surgeon is required, reimbursement is made according to the Nebraska Medicaid Practitioner Fee Schedule. The assistant uses the appropriate modifier with the basic procedure code when submitting a claim (for example, 47600-80 cholecystectomy assist). See 471 NAC 18-003.05 for non-covered surgical assistant fees.

18-004.17B New or Unusual Surgical Procedures: NMAP may cover new or unusual surgical procedures. In all cases, the Medical Director shall determine the necessity or usefulness of the procedure. The physician shall submit requests for NMAP prior authorization by using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or by completing and submitting a written request for prior authorization. Physicians shall obtain prior authorization for these procedures prior to providing the service from -

Medical Director
Medicaid Division
Nebraska Department of Health and Human Services Finance and Support
301 Centennial Mall South, 5th Floor
P.O. Box 95026
Lincoln, NE 68509

If approved, the Department sends a notification of authorization to the provider. The provider(s) shall submit a copy of the notification of authorization only when instructed to do so in the text of the authorization.

18-004.17C Second Surgical Opinion: NMAP makes payment for clients who desire a second physician's opinion concerning proposed surgery. This second physician shall bill the Department with a HCPCS consultation procedure code indicating the level of the consultation and identifying the service as a second surgical opinion on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).
18-004.17D Cosmetic and Reconstructive Prior Authorization Procedures: In addition to the prior authorization requirements under 471 NAC 18-004.01, the surgeon who will be performing the cosmetic or reconstructive (C/R) surgery shall submit a request to the Medical Director. This request must include the following:

1. An overview of the medical condition and medical history of any conditions caused or aggravated by the condition;
2. Photographs of the involved area(s) when appropriate to the request;
3. A description of the procedure being requested including any plan to perform the procedure when it requires a staged process; and
4. When appropriate, additional information regarding the medical history may be submitted by the client's primary care physician.

Prior authorization request for cosmetic and reconstructive surgery must be submitted 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) or in writing by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services Finance and Support
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026

Fax Telephone Number: (402) 471-9092

18-004.17E Services Performed in an Ambulatory Surgical Center: In addition to the federally-identified ASC services, NMAP covers the certain state-defined services provided in an ambulatory surgical center (ASC). Payment for "facility services" provided in connection with the state-defined procedures will not exceed payment for the corresponding group of Medicare-covered ASC procedures. See the state-defined ASC services in 471-000-409.

Federally-identified ASC services are defined in 471 NAC 26-004.
18-004.18 Anesthesiology: NMAP covers anesthesiology services. See 471 NAC 18-004.33D.

18-004.19 Hospital Calls: NMAP reimburses only one primary physician's call per day in the hospital and only one visit per week by a physician consultant unless:

1. Unless the primary physician specifically states on Form CMS-1500 or electronically that more than one call was necessary because of serious illness or change in condition; and
2. Approval is given by the Medical Director.

18-004.19A Surveillance and Utilization Review (SUR) Criteria: The Department may contract with a medical review organization to review inpatient hospital services. The physician shall comply with all medical review requirements. For hospitalizations not subject to medical review, the Department's in-house utilization review will prevail. If a hospitalization is denied or reduced based on utilization review, the physician's claim may also be denied or reduced accordingly.

18-004.20 Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for a medical emergency, accident, or injury (a medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances that may present a substantial risk to an individual's health unless immediate medical assessment and/or treatment is done);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by a physician such as for allergy shots or when traveling (a written referral by the physician must be submitted with the claim);

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly. When the facility or the Department determines service are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charge. When these conditions are met, the physician's fee will be disallowed to the rate of a comparable office service. All other Medicaid allowable charges incurred in this type of visit will be paid according to 471 NAC 10-010.06 ff. for hospitals or according to the Nebraska Medicaid Practitioner Fee Schedule for physicians.
18-004.21 Prenatal, Delivery, and Postpartum Care: Medicaid covers physicians' services related to pregnancy. Routine prenatal care, delivery, six weeks' postpartum care, and routine urinalysis are reimbursed as a "package" service. The physician may claim, as independent procedures, those lab and medical services which are not related to the pregnancy or which are not included as part of the "package" service (i.e., urinalysis for urinary tract infections, treatment of fractures, etc.).

When billing Medicaid for prenatal, delivery, and postpartum care, the provider shall submit a claim at the time of delivery. One charge is submitted covering all -

1. Routine prenatal care, vaginal delivery, and postpartum care; or
2. Routine prenatal care, cesarean delivery, and postpartum care.

When the primary physician does not participate in the total obstetrical care, the partial care (prenatal, delivery, or postpartum care only) may be billed separately from the delivery using the appropriate procedure codes. An explanation for the partial care must be submitted with the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) (i.e., patient moved, delivered elsewhere, aborted, etc.). Providers shall use one procedure code, i.e., for prenatal care only, but shall provide individual dates of service on the claim.

18-004.22 Antigens: Medicaid may make payment for a reasonable supply of antigens that have been prepared for a particular patient even though the antigens have not been administered to the patient by the same physician who prepared them if -

1. The antigens are prepared by a physician who is a doctor of medicine or osteopathy; and
2. The physician who prepared the antigens has examined the patient and determined a plan of treatment and a dosage regimen.

The Department considers a reasonable supply of antigens to be not more than a 12-week supply of antigens that has been prepared for a particular patient at any one time. The reasonable supply limitation ensures that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient.

18-004.23 (Reserved)
18-004.24 Dialysis: NMAP follows Medicare's guidelines for coverage of dialysis.

18-004.25 Drugs

18-004.25A Covered Drugs: NMAP covers outpatient prescription drugs in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA ‘90) (Public Law 101-508) including:

1. Legend drugs;
2. Compounded prescriptions; and
3. Over-the-counter (OTC) drugs indicated as covered on the Nebraska Point of Purchase (NE-POP) System or listed on the Department's website.

See 471 NAC 18-004.25B, Non-Covered Services; 471 NAC 18-004.25C1, Products Requiring Prior Approval; coverage as indicated on NE-POP System; and the Department's website for exceptions to the above.

18-004.25A1 Preferred Drug List (PDL): The Medicaid Prescription Drug Act of 2008 requires the Department to establish and maintain a Preferred Drug List for the Medicaid program with the aid of the Pharmaceutical and Therapeutics Committee. Drugs designated as Preferred Drugs may be prescribed for Medicaid clients without prior authorization from the Department; however, some Preferred Drugs may have clinical claim limits to ensure appropriate use.

The Department will include on the Preferred Drug List prescribed drugs that are found to be therapeutically equivalent to or superior to other drug(s) within a therapeutic class, and the net cost of the drugs are equal to or less than other drugs within a therapeutic class after consideration of applicable rebates or discounts negotiated by the Department or it's designated contractor.

Medications designated as Non-Preferred on the Preferred Drug List will be subject to prior authorization. The Pharmaceutical and Therapeutics Committee will develop criteria for use of medications with non-preferred status.

The Department will maintain an updated Preferred Drug List in electronic format and will make the list available to the public on the Department's internet web site.

18-004.25A2 Compounded Prescriptions: A compounded prescription is a mixture of ingredients which the provider prepares in the pharmacy.

Any mixture of drugs which results in a commercially available OTC preparation is not considered a compounded prescription, for example, dilute HCL, MOM with cascara, OTC hydrocortisone preparations.
18-004.25A3 Over-the-Counter (OTC) Drugs: NMAP covers only OTC drugs indicated as covered on the NE-POP System or listed on the Department's website. OTC drugs must be prescribed by a licensed practitioner.

18-004.25B Non-Covered Services: Payment by NMAP will not be approved for:

1. More than a three-month supply of birth control tablets. More than a three-month supply of oral medication. More than 100 tablets or capsules of medication taken once daily. More than a three-month supply of any medication, except injectable medications. More than a one-month supply of any injectable medication, except insulin and those injectable drugs with a duration of greater than one month from one dose (e.g., Lupron Depot 4 month, Depo-Provera Contraceptive 150mg.).
2. Experimental drugs or non-FDA approved drugs;
3. Drugs or items when the prescribed use is not for a medically accepted indication;
4. Drugs or items prescribed or recommended for weight control and/or appetite suppression;
5. Liquors (any alcoholic beverage);
6. D.E.S.I. drugs (Drug Efficacy Study Implementation Program) and all identical, related, or similar drugs;
7. Personal care items (examples: non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, and contact solutions);
8. Medical supplies and certain drugs for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) patients (see 471 NAC 7-000 and 16-004.07);
9. Over-the-counter (OTC) drugs not listed on the Department's web site;
10. Drugs or items used for cosmetic purposes or hair growth;
11. Baby foods or metabolic agents (Lofenalac, etc.,) normally supplied by the Nebraska Department of Health and Human Services (see 471 NAC 16-002.03 for exceptions);
12. Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the drug rebate program;
13. Products used to promote fertility;
14. Medications dispensed as partial month fills for nursing facility or group home residents when dispensed by more than one pharmacy;
15. Drugs, items or products of manufacturers/labelers that are identifiable as non-covered on the Ne-POP system or on the Department's website;
16. Drugs, classes of drugs or therapeutic categories of drugs that are Medicare Part D Drugs and Medicare Part D Covered supplies or equipment, for all persons eligible for benefits under Medicare Part D, whether or not such persons are enrolled into a Medicare Part D Plan (see 471 NAC 3-004 for definitions of Medicare Part D Drugs, Medicare Part D Covered supplies and equipment, Medicare Part D and Medicare Part D plan); and
17. Drugs or classes of drugs approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction, or drugs or classes of drugs that are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs that are approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction and for conditions other than treatment of sexual or erectile dysfunction, and are prescribed for those other conditions may be covered, but NMAP may require prior authorization. (See 471 NAC 16-004).

18-004.25C Prior Authorization: The Department requires that authorization be granted prior to payment for certain drugs or items. Prior authorization may pertain to either certain drugs prescribed or certain physician administered drugs.

18-004.25C1 Prior Authorization of Prescription Drugs: Physicians wishing to prescribe these drugs must obtain prior authorization by submitting the request either by standard electronic transaction or by phone, fax or mail from either:

1. The Department's NE-POP contractor; or
2. The Pharmacy Consultant (or designee)
   Nebraska Department of Health and Human Services
   Division of Medicaid and Long-Term Care
   P. O. Box 95026
   301 Centennial Mall South, 5th Floor
   Lincoln, NE 68509
   Phone: (877) 255-3092
   FAX: (402) 471-9092
   E-Fax: (402)742-2348

The NE-POP contractor or the Department will respond to any request for prior authorization within 24 hours of receipt of the request.

18-004.25C2 Products Requiring Prior Approval: The following prescribed products require prior approval:

1. Sunscreens (Example: Presun 29, Solbar-50);
2. Certain modified versions, double-strength entities, or products considered by the Department to be equivalent to drug products contained on the state or federal upper limit listings (Example: Libritabs, Keftabs);
3. Human Growth Hormone;
4. Erythropoietin (Example: Epogen, Procrit);
5. Drugs or supplies intended for convenience use (Example: Refresh Ophthalmic 0.3 ml. and Novalin penfil insulin);
6. Drugs used for prevention of infection with respiratory syncytial virus (e.g., respiratory syncytial virus immune globulin, palivizumab); and
7. Certain drugs or classes of drugs used for gastrointestinal disorders, including but not limited to hyperacidity, gastroesophageal reflux disease, ulcers or dyspepsia (examples: omeprazole, famotidine);
8. Certain drugs or classes of drugs used for relief of pain, discomfort associated with musculoskeletal conditions, inflammation or fever (examples: butorphanol, carisoprodol, tramadol);
9. Certain drugs or classes of drugs used for relief of cough and/or symptoms of the common cold, influenza or allergic conditions (examples: loratadine, zanimivir, oseltamivir);
10. Certain drugs or classes of drugs that are used for non-covered services or indications (see 471 NAC 18-004-25B Non-Covered Services) and for covered services or indications (examples: orlistat, sildenafil);
11. Certain drugs or classes of drugs on the state maximum allowable cost or federal upper limit listings;
12. Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins; and
13. Certain drugs or classes of drugs that are used for tobacco cessation; and
14. Certain drugs or classes of drugs that are determined by the Pharmaceutical and Therapeutics Committee to not be placed onto the Preferred Drug List.

Identifiable products requiring approval prior to payment are designated as such on the NE-POP System or on the Department’s website.

18-004.25C3 Prior Authorization of Physician Administered Drugs: Certain drugs administered in the clinical setting also require prior authorization.

Requests for authorization of these products for the Medicaid client in a Medicaid managed care plan must be done by the Managed Care Plan. The provider must contact the client’s managed care plan for their prior authorization guidelines.

Prior authorization of these products for the fee-for-service Medicaid client must be requested from the Department by submitting the request either by standard electronic transaction, mail, or fax to:

Medicaid Medical Director (or designee)
Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
P.O. Box 95026
301 Centennial Mall South, 5th Floor
Lincoln, NE 6850
Fax: (402) 471-9092
Physician administered drugs requiring prior authorization include but are not limited to:

1. Any drug used for the prevention of respiratory syncytial virus infections;
2. Certain drugs used for the treatment of multiple sclerosis;
3. Enzyme replacement therapy (ERT) for Lysosomal Storage Disorders;
4. IgE blocker therapies for asthma;
5. Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins;
6. Services not covered under the Nebraska Medical Assistance Program (NMAP) the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. (See 471 NAC 33-001.04)

Provider bulletins found on the Medicaid website at www.hhss.ne.gov/med/pb/ will give further direction for prior authorization of specific drugs or classes of drugs.

Brand Necessary Certification of Drugs: The Federal Upper Limit (FUL) or State Maximum Allowable Cost (SMAC) limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the usual and customary charge or National Average Drug Acquisition Cost (NADAC) will be the maximum allowable cost. The prescriber must certify on Form MC-6 that a brand name is medically necessary.

Completion of Form MC-6: The Department requires completion of the physician certification form to meet federal requirements. Form MC-6 must:

1. Contain the handwritten signature of the prescribing physician. Rubber stamp signatures, initials, etc., are not acceptable.
2. A separate MC-6 Form is required for each drug product.
3. The original (top) copy of Form MC-6 must be submitted to the Department-designated contractor.
4. The duplicate copies are to be retained by the dispensing pharmacy provider and prescribing physician and serve as their proof of certification. The Department does not provide additional authorization.
5. The original and subsequent drug claims must be checked "dispense as written"; and
6. A new Form MC-6 is required when the effective dates of the certification expire or prescribing physician has changed.
18-004.25E Injections: The Department applies the following limitations to injectable (e.g. subcutaneous, intramuscular, intravenous) drug products:

1. Only those injections that are either self administered by the client or are administered for the client at the client’s place of residence are reimbursable as prescribed (pharmacy) services. Home health services (see 471 NAC 9-000) must meet medical necessity criteria and are not authorized for client or provider convenience.

2. Injections that are administered by the physician in the clinical setting are not reimbursable through the outpatient drug program. Medications used in this manner are considered medical services and are to be purchased, used, and billed to the Department by the physician/clinic.
18-004.26 Family Planning Services: Nebraska Medicaid covers family planning services, including consultation and procedures, provided upon the request of the client. Family planning services and information must be provided to clients without regard to age, sex, or marital status, and must include medical, social, and educational services. The client must be allowed to exercise freedom of choice in choosing a method of family planning. Family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician or registered nurse.

Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

18-004.27 Fracture Care: Initial fracture care includes the application and removal of the first cast or traction device. Providers may claim subsequent replacement of cast and/or traction devices used during or after the period of follow-up care as an independent service using the appropriate HCPCS procedure code.

18-004.28 Practitioner-Administered Medications: Practitioner administered injectable medications will be reimbursed at Average Sales Prices (ASP) + 6% (Medicare Drug Fee Schedule); injectable medications not available on the Medicare Drug Fee Schedule will be reimbursed at Whole Acquisition Cost (WAC) + 6.8%, or manual pricing based on the provider’s actual acquisition cost. Practitioner administered injectable medications, including specialty drugs, purchased through the Federal Public Health Service’s 340B Drug Pricing Program (340B) will be reimbursed at the 340B actual acquisition cost and no more than the 340B ceiling price.

When billing for medications administered during the course of a clinic visit, the physician must use the appropriate Health Care Common Procedure Coding System (HCPCS) procedure code for the medication, the correct number of units per the Health Care Common Procedure Coding System (HCPCS) description, the National Drug Code (NDC) of the drug administered, the National Drug Code (NDC) ‘unit of measure’ and the number National Drug Code (NDC) units. A Current Procedural Terminology (CPT) code for the administration must also be submitted.

When billing for medication that does not have a specific Level I or II code, the physician must use a miscellaneous Health Care Common Procedure Coding System (HCPCS) code with the name and National Drug Code (NDC) number identifying the drug and include the dosage given. If this information is not with the claim, the Department may return the claim to the physician for completion or pay the claim at the lowest dosage manufactured for the specific drug. Payment for service is as described in 18-006 and 18-006.01.
**18-004.28A Allergy Injections:** When the cost of the medication is not available (not listed in either *The Drug Topics Red Book* or *The Blue Book*), allergy injections are paid at the provider’s submitted charge up to the maximum allowable dollar amount under the Nebraska Medicaid Practitioner Fee Schedule per injection which includes medication and injection fee. If the allergy medication is not prepared in the office of the physician administering the allergen and the administering physician incurs no expense for the supply (the supplier bills the Department separately), the Department reimburses the administering physician according to the NMAP Practitioner Fee Schedule for the injection fee. If the administering physician purchases the supply for administration in his/her office, the administering physician must not bill the Department for more than the cost of the supply. The Department must not exceed the maximum allowable dollar amount under the Nebraska Medicaid Practitioner Fee Schedule in reimbursement per allergy injection, which includes the cost of the medication and the injection fee.

**18-004.28B Vitamin B-12 Injections:** The Nebraska Medical Assistance Program does not cover injections which, by accepted standards of medical practice, are not considered specific or effective treatment for the particular condition for which they are given. Professional medical advice indicates that Vitamin B-12 injections are specific therapy for:

1. Gastrectomy;
2. Idiopathic steatorrhea;
3. Ileostomy;
4. Internal cancers;
5. Macrocytic anemia;
6. Megaloblastic anemia;
7. During or after radiation therapy;
8. Certain neuropathies, including posterolateral sclerosis, neuropathies associated with pernicious anemia, the acute exacerbation of a neuropathy due to malnutrition or alcoholism diabetic neuropathy;
9. Pernicious anemia, including primary anemia, Addisons, essential, idiopathic, malabsorption, Biemer's cyogenic, and malignant; and
10. Post-surgical and mechanical disorders, such as gastrectomy or re-section of small intestines.
NMAP covers Vitamin B-12 injections only when the claim shows one of these diagnoses.

18-004.28C  Influenza Injections in Long Term Care Facilities: Because the services of a nurse to give injections are included in the compensation for long term care facilities, no payment is made to a physician giving influenza injections in these facilities.

18-004.28D Injectable Estrogens: NMAP does not pay for injectable estrogens for depression or osteoporosis associated with menopause.

18-004.28E  Liver and Vitamin Injections: The Department does not pay for liver and vitamin injections.

18-004.28F  Chemotherapy: Providers must bill for chemotherapy on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49), using HCPCS procedure codes for chemotherapy administration. One line is used for administration; a separate line is used for the drug. The drug used must be identified and claimed separately on the claim using the appropriate HCPCS procedure code, the number of units per the HCPCS description, the NDC of the drug administered, the NDC 'unit of measure', and the number of NDC units. For drugs that do not have a specific HCPCS code, the provider must use a miscellaneous chemotherapy code. The provider must indicate on or in the claim the name of medication, the dosage administered, the NDC number, NDC ‘unit of measure’, and the number of NDC units.

18-004.28G Immunizations: Routine immunizations are available to Medicaid covered children and adolescents from birth through age 20 under the EPSDT program. Vaccines for those clients age 18 and younger are available through the Vaccine for Children (VFC) program; NMAP will not reimburse for a physician’s private stock vaccine when the vaccine is available through the VFC program.

When using VFC vaccines, only the administration is to be billed to the Department. This is done by adding the appropriate modifier to the vaccine code; see claim submission instructions for more detailed information. The billed charge for the administration must not exceed the VFC federally determined state maximum for Nebraska. Contact the Nebraska VFC program with any questions regarding the state maximum.

Medicaid reimbursement is available for the provider’s private stock vaccine and the administration fee for immunizations of adolescents age 19 and 20.

Immunizations for adults (age 21 and older) are covered by Medicaid on a case by case basis for medical necessity.

It is not necessary to submit an NDC when billing for vaccines.

18-004.29 Laboratory Services: Laboratory services are microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or pathological examinations or procedures performed on materials derived from the patient to provide information for the diagnosis or treatment of a disease or an assessment of the medical condition of the patient. These services may be provided in -

1. A physician’s or group of physicians’ private office;
2. A licensed/certified independent clinical laboratory; and
3. A hospital whose certification covers services performed in the laboratory.
18-004.29A Physician's Office Laboratory: A laboratory which a physician or a group of physicians maintains for performing diagnostic tests in connection with his/her own or the group practice is not considered an independent clinical laboratory.

If the services are provided in a physician's or group of physician's private office, payment may be claimed for the medically necessary services provided or supervised by the physician(s), using the appropriate HCPCS procedure code.

Payment for tests obtained in the physician's office but sent to an independent clinical lab or hospital for processing must be claimed by the facility performing the tests, using the appropriate HCPCS procedure code. The private physician's office may be reimbursed for the collection by venipuncture or catheterization for these procedures by using the appropriate HCPCS procedure code. Payment for service is as described in 18-006 and 18-006.01. The Department does not reimburse the private physician(s) for processing or interpreting tests performed outside his/her office.

18-004.29B Licensed/Certified Independent Clinical Laboratories: An independent clinical laboratory must have a separate provider agreement with the Department (see 471 NAC 18-001.02).

A radiological laboratory is not considered an "independent laboratory" under Medicaid. An independent clinical laboratory is one which is independent both of an attending or consulting physician's office and of a hospital. A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered a consulting physician.

A laboratory which is operated by or under the supervision of a hospital (or the organized medical staff of the hospital) which does not meet the definition of a hospital is considered to be an independent laboratory. However, a laboratory serving hospital inpatients and outpatients and operated on the premises of a hospital which meets the definition of a hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not classified as an independent clinical laboratory. The hospital's certification covers the services performed in this laboratory.
NMAP may cover laboratory tests that have been referred by one independent lab to another.

The Department does not reimburse a lab for handling services for tests referred to a second lab.

When a physician's private office sends the specimen to an independent clinical lab for processing, the Department pays for the procedure directly to the independent clinical lab. The Department does not reimburse the lab for collecting, handling, or drawing the specimen, sent in by a physician's office. The Department pays for specimens collected by venipuncture or catheterization obtained by the hospital or independent lab for hospital or independent lab patients. The Department does not reimburse the private physician for processing or interpreting tests performed outside his/her office. The Department does not allow reimbursement for collection of specimens in a nursing home or long term care facility.

If a physician performs some tests on a specimen and then sends the same specimen to an outside facility for additional procedures, the private physician may be reimbursed for the medically necessary procedures performed in his/her office plus a fee for drawing the specimen by venipuncture or obtaining urine by catheterization sent to a hospital or independent lab. The physician must indicate on or with the appropriate claim form or electronic format (see Claim Submission Table at 471 NAC 18-000-49) that the fee for obtaining the specimen by venipuncture or catheterization is for tests performed outside his/her office and submit the name of the facility performing the tests on the claim.

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

**18-004.30 Radiology Services:** Radiology services are medically necessary services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic services and associated medical services necessary for the diagnosis and treatment of a patient. These services may be provided in -

1. A physician's or group of physicians' private office; or
2. A hospital whose certification covers the radiological services provided.

Claims for radiology procedures must have at least a provisional diagnosis or statement of symptoms. NMAP will not accept claims with a diagnosis of "routine radiology."

**18-004.30A Prior Authorization of Radiology Procedures:** Effective September 1, 2009, all non-emergency outpatient Computerized Tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans will require prior authorization. These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room.
18-004.30B Physician's Private Office: When both the technical and professional components of medically necessary radiological procedures are performed in a physician's private office, NMAP may reimburse the physician's private office for the total procedure.

18-004.30C Hospital Radiology Services: When a physician orders medically necessary radiological services performed in a hospital, NMAP makes payment directly to the hospital and/or radiologist according to the terms of the financial arrangements between the hospital and the radiologist. NMAP does not reimburse the private physician(s) for interpreting radiology procedures performed outside his/her office.

18-004.30 Mammograms: NMAP covers mammograms when provided based on a medically necessary diagnosis. In the absence of a diagnosis, NMAP covers mammograms provided according to the American Cancer Society's periodicity schedule.

18-004.31 Ultrasound Diagnostic Procedures: NMAP covers ultrasound diagnostic procedures listed by Medicare under Category I. NMAP may review claims for these procedures to ensure that the techniques are medically appropriate and the general indications of Medicare's categories are met.

Because of rapid changes in the field of ultrasound diagnosis with respect to new diagnostic uses and medical appraisal of the safety and effectiveness of existing techniques, claims for uses other than those listed under Medicare's Category I will be reviewed before payment.

NMAP does not cover ultrasound procedures listed by Medicare under Category II.

18-004.32 Computerized Tomography (CT) Scans: NMAP covers diagnostic examinations of the head (head scans) and of certain other parts of the body (body scans) performed by computerized tomography (CT) scanners when -

1. Medical and scientific literature and opinion support the use of a scan for the condition;
2. The scan is reasonable and necessary for the individual patient; and
3. The scan is performed on a model of CT equipment that meets Medicare's criteria for coverage.
To be determined reasonable and necessary for the individual patient as required in item 2, the use of the CT scan must be medically appropriate considering the patient's symptoms and preliminary diagnosis. The Department may determine that the use of a CT scan as the initial diagnostic test was not reasonable and necessary because it was not supported by the patient's symptoms and complaints stated on the claim form or electronic format. The Department reviews claims for CT scans for evidence of abuse, such as the absence of reasonable indications for the scans, an excessive number of scans, or unnecessarily expensive types of scans.

18-004.33 Professional and Technical Components for Hospital Inpatient and Outpatient Diagnostic and Therapeutic Services: Hospital diagnostic and therapeutic services are procedures performed to determine the nature and severity of an illness or injury, or procedures used to treat disease or disorders. Hospital diagnostic and therapeutic services include both inpatient and outpatient hospital services.

Hospital diagnostic and therapeutic services are comprised of two distinct elements: the professional component and the technical component. Hospital services which have professional and technical components include but may not be limited to -

1. Pathology:
   a. Anatomical;
   b. Clinical;
2. Radiology;
3. Specialized diagnostic and therapeutic services:
   a. CT scans;
   b. Nuclear medicine;
   c. Dialysis treatments;
   d. Radiation therapy;
   e. Ultrasound;
4. Anesthesia;
5. Psychiatric services; and
6. Miscellaneous:
   a. Pulmonary function tests;
   b. EEG's; and
   c. EKG's.

NMAP may designate other services as having professional and technical components when the services are identified.
18-004.33A  Professional Component: The professional component of hospital diagnostic and therapeutic services includes those physician's services directly related to the medical care of the individual patient (i.e., interpretation of laboratory tests, x-rays, EKG's, EEG's, etc.). A physician includes not only a specialist but also a physician who normally performs or supervises these services for all inpatients and outpatients of a hospital, even though the physician does not otherwise specialize in this field (i.e., laboratory, radiology, cardiopulmonary).

The professional component must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (except for facilities paid under an all-inclusive rate) using the appropriate HCPCS code and where appropriate, modifier for professional component.

18-004.33A1  Coverage Conditions: To be covered as a professional component, the physician's services must -

1. Be personally provided to an individual patient by a physician;
2. Contribute directly to the diagnosis or treatment of an individual patient;
3. Ordinarily require performance by a physician;
4. Be medically necessary; and
5. For anesthesiology, laboratory, or radiology services, meet the requirements of 471 NAC 18-004.33D, 18-004.33E, and 18-004.33F.

18-004.33A2  Payment: The Department pays for the professional component of a physician's hospital diagnostic or therapeutic service as described in 471 NAC 18-006 ff. Payment for the professional component of a radiology service provided in a hospital is made according to the Nebraska Medicaid Practitioner Fee Schedule.

In the absence of available payment data as described in 471 NAC 18-006 ff., the Department pays for the professional component at a percentage of the Department's allowable fee for the total procedure. The percentage is established by the Department.

18-004.33B  Technical Component: The technical component of hospital diagnostic and therapeutic services is comprised of two distinct elements:

1. Physicians' professional services not directly related to the medical care of the individual patient (i.e., teaching, supervision, administration, and other services that benefit the hospital's patients as a group); and
2. Hospital services (i.e., equipment, supplies, technicians, etc.).
The technical component for hospital inpatients and outpatients must be claimed by the hospital.

The Department's payment for the technical component includes payment for all non-physician services required to provide the procedure, such as stat fee, specimen handling, call back, room charges, etc.

18-004.33B1 Non-Physician Services and Items: The elimination of combined billing requires the separation of physician services (professional component) from non-physician services (technical component) for billing purposes.

All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics, prosthetics, etc.) provided to hospital inpatients or outpatients must be billed by the hospital and must be provided directly by the hospital or under arrangements. If the services or items are provided under arrangements, the hospital is responsible for payment to the non-physician provider or supplier. The Nebraska Medical Assistance Program prohibits the "unbundling" of costs by hospitals for non-physician services or supplies provided to hospital patients, including ancillary services provided by another hospital.

All other non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics, and prosthetics, etc.) provided to non-patients for primary use in other than the hospital setting must be billed by the provider/supplier of the service or item on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Exception: Take-home supplies and rental of apnea monitors.

Payment for the technical component for a medically necessary service required and/or ordered by a physician must be claimed by the hospital as a hospital service on the hospital claim form or electronic format.

18-004.33B1a Inpatient Services: All non-physician services, drugs, and items provided to hospital inpatients must be billed by the hospital. The hospital per diem includes payment for ancillary services, including outpatient services provided by another hospital to an inpatient (see 471 NAC 10-010.03 ff.). The hospital is responsible for payment to the non-physician provider or supplier.

18-004.33B1b Outpatient Services: All non-physician services, drugs, and items provided to hospital outpatients must be billed by the hospital. Payment for these services is made according to 471 NAC 10-010.06 ff. The hospital is responsible for payment to the non-physician provider or supplier.
All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics and prosthetics, etc.) provided for primary use in the emergency room or outpatient facility must be billed by the hospital as outpatient services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

All non-physician services, drugs, medical supplies, and items provided to non-patients for primary use in other than the outpatient facility or emergency room must be billed by the non-physician provider or supplier on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Exception: Apnea monitors.

The sale or rental of durable medical equipment for primary use in the patient's home or nursing home must be billed by the supplier on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Exception: Apnea monitors.

18-004.33B1c Inpatient Fittings: Fittings for durable medical equipment, orthotics and prosthetics, etc., provided to a hospital inpatient when the item itself is provided while the client is an inpatient must be billed by the hospital as an ancillary service. The hospital is responsible for payment to the supplier.

Fittings for durable medical equipment, orthotics and prosthetics, etc., provided to a hospital inpatient when the item itself is provided after the client is dismissed from the hospital must be billed by the supplier directly to the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

18-004.33C Billing for the Professional and Technical Components of Hospital Inpatient and Outpatient Diagnostic and Therapeutic Services: The professional component of hospital diagnostic and therapeutic services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49), except for facilities paid under an all-inclusive rate. The technical component of hospital diagnostic and therapeutic services must be billed by the hospital.

A hospital may act as the billing agent for the physician's professional component.

Because Medicare assigns a separate provider number to each specialty for the hospital professional component, the Department requires a separate Medicaid provider number for each specialty for the hospital professional component. A separate provider agreement is required for each separate provider number. The professional component must be billed on the claim, using the appropriate provider number for the professional component of the appropriate specialty.

Only one specialty (one provider number) may be billed on each claim.
18-004.33C1  Pre-Admission Testing: NMAP does not cover pre-admission testing performed in a physician's office which is performed solely to satisfy hospital pre-admission requirements.

18-004.33D  Anesthesiology

18-004.33D1  Professional Component: The Department covers, as a physician's service, the professional component of anesthesiology services provided by a physician to an individual patient if the conditions in 471 NAC 18-004.33A1 are met. The professional component must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Claims for these services must indicate actual time in one-minute increments.

18-004.33D2  Medical Direction of Four or Fewer Concurrent Procedures: The professional component for the physician's medical direction of concurrent anesthesiology services provided by qualified anesthetists, such as certified registered nurse anesthetists (CRNA's), is covered as a physician's service when the services meet the requirements listed in 471 NAC 18-004.33A1 and the following additional requirements:

1. For each patient, the physician -
   a. Performs and documents a pre-anesthetic examination and evaluation;
   b. Prescribes the anesthesia plan;
   c. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
   d. Ensures that any procedures in the anesthesia plan that s/he does not perform are performed by a qualified individual;
   e. Monitors the course of anesthesia administration at frequent intervals;
   f. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
   g. Provides indicated post-anesthesia care; and

2. The physician directs no more than four anesthesia procedures concurrently, and does not provide any other services while directing the concurrent procedures (see 471 NAC 18-004.33D2a).
The physician's medical direction of four or fewer concurrent anesthesia procedures is considered a professional component and must be billed on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837).

18-004.33D2a Other Services Provided While Directing Concurrent Procedures: A physician who is directing concurrent anesthesia services for four or fewer surgical patients must not ordinarily be involved in providing additional services to other patients. The following situations are examples of services that do not constitute a separate service for determining medical direction in item 2 of 471 NAC 18-004.33D2:

1. Addressing an emergency of short duration in the immediate area;
2. Administering an epidural or caudal anesthetic to ease labor pain;
3. Periodic, rather than continuous, monitoring of an obstetrical patient;
4. Receiving patients entering the operating suite for the next surgery;
5. Checking or discharging patients in the recovery room; or

If the physician leaves the immediate area of the operating suite for longer than short durations, devotes extensive time to an emergency case, or is otherwise not available to respond to the immediate needs of surgical patients, the physician's services to the surgical patient are supervisory in nature and are considered a technical component; therefore, these services must be billed as the technical component by the hospital.

18-004.33D3 Supervision of More Than Four Concurrent Procedures: If the physician is involved in providing supervision for more than four concurrent procedures or is performing other services while directing four or fewer concurrent procedures, the physician's services are considered a technical component of hospital services. The physician shall ensure that a qualified individual performs any procedure in which the physician does not personally participate. The physician's personal services up to and including induction are considered the professional component.

18-004.33D4 Standby Anesthesia Services: A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs and ready to furnish anesthesia services to a specific patient who is known to be in potential need of services. The professional component must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

18-004.33D5 Claims for Payment: When a physician bills for anesthesia services, the physician shall certify with the claim, as appropriate, that -
1. The services were personally provided by the physician to the individual patient; or
2. When the physician provided medical direction for CRNA services, the number of concurrent services directed is indicated by the appropriate modifier.

To make payment for anesthesia services for sterilizations, a properly completed and legible copy of Form MMS-100, “Sterilization Consent Form” (see 471-000-109) must be on file with the Department.

For a hysterectomy, a properly completed copy of Form MMS-101, signed and dated by the client stating she was made aware before the surgery that the surgery would result in sterility must be on file with the Department before payment can be made.

See 471 NAC 18-004.07 for exceptions to informed consent forms for hysterectomies.

Claims for these services must indicate actual time in one-minute increments.

Also see 471 NAC 18-004.18 and 18-004.47.

18-004.33D6 Payment for Anesthesiology Services: NMAP pays for covered anesthesiology services at the lower of –

1. The provider’s submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee schedule in effect for that date for service.

NMAP does not make additional reimbursement for emergency and risk factors.

Also see 471 NAC 18-004.47.

18-004.33E Laboratory

18-004.33E1 Professional Component: The Department covers as a physician's service the professional component of laboratory services provided by a physician to an individual patient only if the services meet the requirements listed in 471 NAC 18-004.33A1 and are -

1. Anatomical pathology services;
2. Consultative pathology services, which must -
   a. Be requested by the patient’s attending physician;
   b. Relate to a test result that lies outside the clinically significant normal or expected range in view of the patient's condition;
   c. Result in a written narrative report included in the patient's medical record; and
d. Require the exercise of medical judgment by the consulting physician; or
3. Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

18-004.33E2 Technical Component: Clinical laboratory services provided to hospital inpatients, outpatients, and non-patients are routinely performed by non-physicians (i.e., medical technologists or laboratory technicians) or by automated laboratory equipment. These clinical laboratory services do not require performance by a physician and are considered the technical component; there is no professional component for these services. The technical component must be billed by the hospital on the appropriate claim form or electronic format. (See claim submission table at 471-000-49).

18-004.33E3 Anatomical Pathology Services: Anatomical pathology services are services which ordinarily require a physician's interpretation. If these services are provided to hospital inpatients or outpatients, the professional and technical components must be separately identified for billing and payment.

18-004.33E4 Billing and Payment for Inpatient Hospital Anatomical Pathology Services: Payment for the technical component of anatomical pathology is included in the hospital's payment.

The pathologist shall claim the professional component of anatomical pathology on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure code and modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

Exception: If an anatomical pathology specimen is obtained from a hospital inpatient but is referred to an independent laboratory or the pathologist of a second hospital's laboratory, the independent lab or the pathologist of the second hospital's laboratory to which the specimen has been referred may claim payment for the total service (professional or technical components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.33E5 Billing and Payment for Outpatient Hospital Anatomical Pathology Services: The hospital shall claim the technical component on the appropriate claim form or electronic format (see claim submission table 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The pathologist shall claim the professional component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure code and modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.
Exception: If an anatomical pathology specimen is obtained from a hospital outpatient and is referred to an independent lab or the pathologist of a second hospital's laboratory, the independent lab or the pathologist of a second hospital's laboratory to which the specimen was referred may claim payment for the total service (professional and technical components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.33E6 Billing and Payment for Non-Patient Anatomical Pathology Services: A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. For specimens from non-patients referred to the hospital, the hospital shall bill the total service (both professional and technical components) on the appropriate institutional claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.066 ff.

18-004.33E7 Leased Departments: If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist shall claim the total service (professional and technical components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

Leased department status has no bearing on billing for or payment of inpatient or outpatient anatomical pathology services.

18-004.33E8 Clinical Lab Services: The professional and technical components of clinical lab services are not separately identified for billing and payment. Clinical lab services provided to inpatients, outpatients, and non-patients of a hospital are claimed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made to the hospital as follows:

1. Inpatient Services: Payment is included in hospital's prospective payment rate.
2. Outpatient Services: Payment is made according to the fee schedule determined by Medicaid.
3. Non-Patient Services: Payment is made according to the fee schedule determined by Medicaid.

There is no separate payment made to the pathologist for routine clinical lab services. To be paid, the pathologist must negotiate with the hospital to arrange a salary/compensation agreement.

18-004.33E9 Physician's Office or Independent Lab: Clinical lab services performed in a physician's office or independent lab must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is based on the Medicaid fee schedule for clinical laboratory services to cover the total service (professional and technical components). (See 471-000-520).
18-004.33E10  Clinical Lab Consultation:  A physician may claim a clinical lab consultation if the service -

1. Is requested by the patient's attending physician;
2. Relates to a test result that lies outside the clinically significant normal or expected range for the patient's condition;
3. Results in a written narrative report which is included in the patient's record; and
4. Requires the exercise of medical judgment by the consulting physician.

The physician shall claim a clinical lab consultation using the appropriate HCPCS procedure codes.

18-004.33E11  Leased Departments:  Leased department status has no bearing on billing or payment for clinical lab services. The hospital shall claim all clinical lab services, whether performed in a leased or non-leased department. Payment for the total service (professional and technical component) is made to the hospital. The Department does not make separate payment for the professional component for clinical lab services.

18-004.33F  Radiology:  All radiology services have a technical component and a professional component (physician interpretation). The professional and technical component of hospital services must be separately identified for billing and payment.

18-004.33F1  Professional Component:  The professional component of radiology services provided by a physician to an individual patient is covered as a physician's service when the services meet the requirements listed in 471 NAC 18-004.33A1 and the services are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The professional component must be billed on the appropriate claim or electronic format (see claim submission table 471-000-49).
18-004.33F2 Technical Component: The technical component of radiology services to the hospital, such as administrative or supervisory services or services needed to produce the x-ray films or other items that are interpreted by the radiologist, must be billed by the hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

18-004.33F3 Billing and Payment for Inpatient Radiology Services: Payment for the technical component of inpatient radiology services is included in the hospital's payment.

Physicians must bill the professional component of inpatient radiology services on the appropriate claim form or electronic format (see claim submission table 471-000-49) using the appropriate HCPCS procedure code with modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.33F4 Billing and Payment for Outpatient Radiology Services: The hospital must claim the technical component of outpatient radiology services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The physician must bill the professional component on the appropriate claim form or electronic format (see claim submission table 471-000-49) using the appropriate HCPCS procedure code with the modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.33F5 Billing and Payment for Non-Patient Radiology Services: A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. If a radiology procedure is performed for a non-patient, the hospital must claim the total component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

If the radiology department is leased and the service is provided to a non-patient, the radiologist must claim the total service (both technical and professional components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.
18-004.34 **Non-Physician Care Providers:** Nebraska Medicaid covers services provided by "non-physician care providers" under the following conditions:

1. The non-physician care provider must meet the following definition: An individual trained to assist or act in the place of a physician, such as physician assistant, medical specialty assistant, medical services assistant, clinical associate, surgical assistant (graduate physician assistant who has completed a CAHEA accredited surgical residency program), who has received the training required by the specific title;
2. The service provided by the non-physician care provider must be within the scope of practice as defined by state law; and
3. The non-physician care provider must provide the services under a practice agreement between the non-physician care provider and his/her supervising physician, and must be approved by the Board of Medicine and Surgery in the Nebraska Department of Health and Human Services or the appropriate licensing agency in the state in which s/he provides the services.

18-004.34A **Physician Assistant Services:** Nebraska Medicaid covers physician assistant services under the following guidelines: To participate in Nebraska Medicaid, the physician assistant must be licensed by the Nebraska Department of Health and Human Services Division of Public Health as required by 172 NAC 90. The written scope of practice agreement between the physician assistant and the physician must be on file as required by Neb. Rev. Stat. § 38-2050. The physician assistant is approved for enrollment under a group provider agreement with the physician with whom s/he has a practice agreement. Nebraska Medicaid covers those services determined to be medically necessary.

18-004.34B **Payment for Services Provided by Physician Assistants:** Nebraska Medicaid covers services of physician assistants to the extent that they are legally authorized to practice in Nebraska. Payment to physician assistants is made to the physician provider group number with whom the physician assistant is enrolled. When payment is made to the physician group, the physician is responsible for payment to the physician assistant. Payment for physician assistant services is made according to 471 NAC 18-006. Claims for services provided by physician assistants must be submitted on Form CMS-1500 or the standard electronic Health Care Claim:

Professional transaction (ASC X12N 837) under the physician assistant’s provider group number.

18-004.34C **:** Nebraska Medicaid will not make payments to physicians assistants who are employed by a hospital.

18-004.35 (Reserved)
18-004.36 Initial Certification (SNF, ICF, and ICF/MR): Facility staff shall obtain a signed and dated Form DM-5 that corresponds to the nursing home admission date or the date eligibility is determined. Form DM-5 serves as the certification required by federal regulations. The physician shall examine the client before completing the certification, within the following time frames:

1. For SNF Clients: The client must have a physical examination within 48 hours (two working days) after admission unless an examination was performed within five days before admission.
2. For ICF Clients: The client must have a recent physical examination (within 30 days before admission or the date eligibility was determined, or within 48 hours [two working days] after admission or the date eligibility was determined.

The physician may bill the Department for an annual nursing home physical exam service, regardless of the extent of the exam. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

If the admission is a facility-to-facility transfer, local office staff shall obtain a copy of the client's annual history and physical, if it is current to the client's condition (within 30 days before the transfer), and attach it to the signed and dated Form DM-5. The physician may bill the Department for a recertification service. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.36B Annual Physical Examination: The Nebraska Department of Health and Human Services Finance and Support requires that all long term care facility residents have an annual physical examination. The physician, based on his/her authority to prescribe continued treatment, determines the extent of the examination for NMAP clients based on medical necessity. The Department does not cover routine laboratory and radiology services which are not directly related to the patient's diagnosis and treatment; however, for the annual physical exam, a CBC and urinalysis are not considered "routine" and are reimbursed based on the physician's orders when noted on the claim that these services were performed for an annual physical exam for a nursing home client. The results of the examination must be recorded in the client's medical record.

If the annual physical examination is performed solely to meet the requirement of the Department, the physician shall submit the claim to the Department on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The Department limits reimbursement for this service to the amount allowed under the Nebraska Medicaid Practitioner Fee Schedule.

18-004.36C Medicare Coverage: If a physical examination is performed for diagnosis and/or treatment of a specific symptom, illness, or injury and the client has Medicare coverage, the physician shall submit the claim through the usual Medicare process. This applies to all physicians' visits in a long term care facility.
18-004.36D Physicians' Services for Skilled Nursing Facility (SNF) Clients

18-004.36D1 Physician's Visits: The physician shall see the SNF client whenever necessary, but at least once every 30 days for the first 90 days following admission. After the 90th day following admission, an alternate schedule for physician's visits not to exceed 60 days may be adopted if the attending physician determines, and justifies in the client's medical record, that the client's condition does not require visits at 30-day intervals. The facility's Utilization Review Committee shall approve the alternate schedule.

At the time of each visit, the physician shall document the visit in the client's medical record, and write and sign a progress note on the client's condition.

18-004.36D1a Billing for Physicians' Visits to SNF Clients: When billing for a physician's visit, the physician shall use the appropriate HCPCS procedure code for a nursing home visit.

Because the Department requires these services, they may not be covered by Medicare.

18-004.36D2 Review of Plan of Care: The physician and facility staff involved in the SNF client's care shall review each plan of care every 60 days. This should be done in conjunction with a physician's visit or recertification.

18-004.36D3 Recertification: For SNF clients, the physician or the physician's assistant shall recertify in writing the client's continued need for the current level of care every 30 days for the first 90 days and every 60 days thereafter, and at any time the client requires a different level of care.

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.

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

The physician, physician's assistant, or nurse practitioner shall date the recertification at the same time it is signed.
Facility staff shall maintain the recertification in the client's medical record in the facility or building where the client resides.

18-004.36D3a On-Site Recertification: The physician shall record recertifications accomplished by on-site visits to the facility in the client's record. The physician is paid according to the Nebraska Medicaid Practitioner Fee Schedule. The physician shall use the appropriate HCPCS procedure code for nursing home visits when billing NMAP for this service.

18-004.36E Physicians' Services for Clients in Intermediate Care Facilities (ICF's) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's)

18-004.36E1 Physician's Visits: The physician shall see the ICF client whenever necessary, but at least once every 60 days, unless the physician determines that the frequency is not necessary and establishes an alternate schedule not to exceed one year, and records the reason in the medical record. The physician must actually see the patient to claim the service.

At the time of each visit, the physician shall document the visit in the client's medical record, and write and sign a progress note on the client's condition.

18-004.36E1a Billing for Physicians' Visits to ICF and ICF/MR Clients: When billing for a physician's visit, the physician shall use the appropriate HCPCS procedure code. The physician shall submit following statements on or with the claim: "60-day (or alternate schedule) intermediate examination."

Because the Department requires these services, they may not be covered by Medicare.
18-004.36E2  Review of Plan of Care: The interdisciplinary team, which includes the physician, shall review each ICF plan of care every 90 days. This should be done in conjunction with recertification and is not reimbursed separately.

18-004.36E3  Recertification: The physician 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 interagency 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, the recertification clearly identifying himself/herself.

The physician, physician’s assistant, or nurse practitioner shall date the recertification at the same time it is signed.

Facility staff shall maintain the recertification in the client’s medical record in the facility or building where the client resides.

18-004.36E3a  On-Site Recertification: The physician shall record recertifications accomplished by on-site visits to the facility in the client's record. The physician is paid according to the Nebraska Medicaid Practitioner Fee Schedule. The physician shall use the appropriate HCPCS procedure code for nursing home visits when billing NMAP for this service.
18-004.37 Rural Health Clinics: Rural health clinic services are defined as the following services provided by a rural health clinic that is certified in accordance with 42 CFR Part 481:

1. Services provided by a physician within the scope of practice of his/her professional under state law (and with NMAP guidelines), if the physician provides the services in the clinic, or the services are provided away from the clinic and the physician has an agreement with the clinic providing that s/he will be paid by the clinic for the service;
2. Services provided by a mid-level practitioner if the services are provided in accordance with 42 CFR 405.2414(a); and
3. Services and supplies that are provided incident to professional services provided by a physician or a mid-level practitioner.

18-004.38 Telephone Consultations: NMAP does not make payment for telephone calls to or from a patient, pharmacy, nursing home, or hospital. NMAP may make payment for telephone consultations with another physician if the name of the consulting physician is indicated on or in the claim.

18-004.39 Definitions and Terms of Commonality: Current Procedural Terminology - Fourth Edition (CPT-4) contains terms and phrases common to the practice of medicine. Claims for physicians' services must be coded according to the definitions in the CPT-4. The provider shall submit copies of NMAP clients' medical records which NMAP may require to document the level of care provided when the Department requests them. If the requested documentation is not provided or is insufficient in contents, payment may be withheld or refunded. NMAP recognizes the definitions and reporting requirements of the CPT, but coverage is based on regulations in this title.

18-004.40 Medical Transplants: NMAP covers transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the Medical Director of the Medicaid Division shall determine whether the transplant is medically necessary or non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance program covers liver or heart transplantation when the written opinions of two physicians specializing in the specific transplantation state that a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the patient's life in a meaningful, qualitative way and at a reasonable level of functioning.

NMAP is the payor of last resort.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 18-004.40D). An exception may be made for emergency situations, in which case verbal approval is obtained and the notification of authorization is sent.
18-004.40A Services for an NMAP-Eligible Donor: NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

18-004.40B Services for an NMAP-Ineligible Donor: NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment for complications related to the donor is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are no directly related to the transplant.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 18-004.20D).

18-004.40C Billing for Services Provided to an NMAP-Ineligible Donor: Claims for services provided to an NMAP-ineligible donor must be submitted under the NMAP-eligible client's case number. There must be a notation with the claim that these services were provided to the NMAP-ineligible donor on the client's behalf.

18-004.40D Prior Authorization: Physicians shall request prior authorization before performing any transplant service or related service. The physician shall submit requests for NMAP prior authorization in writing or electronically using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50). Physicians shall obtain prior authorization prior to providing the service from -

The Medical Director
Medicaid Division
Nebraska Department of Health and Human Services Finance and Support
301 Centennial Mall South
P. O. Box 95026
Lincoln, NE 68509

The request must include at a minimum -
1. The patient's name, age, diagnosis, pertinent past medical history and treatment to this point, prognosis with and without the transplant, and the procedure(s) for which the authorization is requested;

2. The patient's Nebraska Medicaid number;

3. Name of hospital, city, and state where the service(s) will be performed. The Department's policy regarding out of state services remains in effect. See 471 NAC 1-004.04;

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

5. If authorization is requested to the above information, two physicians shall also supply the following:
   a. The screening criteria used in determining that a patient is an appropriate candidate for a liver or heart transplant;
   b. The results of that screening for this patient (i.e., the patient is eligible to be placed on "waiting list" in which the only remaining criteria is organ availability); and
   c. A statement by each physician -
      (1) Recommending the transplant; and
      (2) Certifying and explaining why a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the client's life in a meaningful, qualitative way and at a reasonable level of functioning.

The Nebraska Department of Health and Human Services Finance and Support, Medical Director, shall send a response to the provider(s) advising them of the approval or denial of Medicaid payment of the requested transplant.

18-004.40E Payment for Liver or Heart Transplant Services: Only those services which are determined by the NMAP to be medically necessary and appropriate will be considered for Medicaid payment. The Department reserves the right to request any medical documentation from the patient's record to support and substantiate claims submitted to the Department for payment. These records may include but are not limited to office records, hospital progress notes, doctor's orders, nurses notes, consultative reports, hospital admission history and physical, and discharge summary.

18-004.40E1 Inpatient Hospital Services: Payment basis for inpatient hospital services is established under 471 NAC 10-010.05.

Procurement costs include removal of organ, transportation, and associated costs. These costs must be billed by the hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) and separately identified on the Medicare cost report.

Payment of the technical component of inpatient laboratory and diagnostic and therapeutic radiology services will be included in the hospital's payment for inpatient services.
18-004.40E2 Limitations to Payment for Inpatient Hospital Services: NMAP will pay the special inpatient hospital rate for no more than five days before the liver or heart transplant until discharge to an alternate level of care (i.e., ambulatory room and board). The liver or heart transplant recipient must meet the criteria established at 471 NAC 18-004.40D. and must be registered as an inpatient before the Department pays this rate.

18-004.40E3 Ambulatory Room and Board: The Department may cover ambulatory room and board services for liver or heart transplant patients (for the client and an attendant, if necessary).

18-004.40E4 Outpatient Hospital Services: All services not provided on an inpatient basis will be paid at the rates established under NMAP. For laboratory and radiology services, see the elimination of combined billing regulations at 471 NAC 18-004.33.

18-004.40E5 Physician Services: Surgeon(s) services will be paid according to the Nebraska Medicaid Practitioner Fee Schedule. This fee will include two weeks' routine post-operative care by the designated primary surgeon. Payment for routine post-operative care will not be made to other members of the surgical team.

Services provided after the two-week post-operative period may be billed on a fee-for-service basis. Also see 471 NAC 18-004.19.

Physician services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).
18-004.41 Itinerant Physician Visits: NMAP covers non-emergency physician visits provided in a hospital outpatient setting if the services are -

1. Provided by an out-of-town specialist who has a contractual agreement with the hospital. NMAP does not consider general practitioners or family practitioners to be specialists; and
2. Determined to have been provided in the most appropriate place of service (see 471 NAC 2-006.01).

The hospital room charge must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The physician’s service must be coded as an office visit and billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). The physician will be paid at the rate for the appropriate level of office visit.

18-004.42 Nurse-Midwife Services: The Nebraska Medical Assistance Program covers nurse-midwife services under the following guidelines.

To participate in the Nebraska Medical Assistance Program, the nurse-midwife must be certified by the Nebraska Department of Health and Human Services Regulation and Licensure. The practice agreement between the nurse-midwife and the physician must be on file with the Department of Health and Human Services Regulation and Licensure. The nurse-midwife is approved for enrollment in NMAP under a group provider agreement with the physician with whom s/he has a practice agreement.

NMAP covers nurse-midwife services that are medically necessary in accordance with his/her scope of practice as defined by law.

NMAP does not cover routine office visits to a physician when a nurse-midwife is providing complete obstetrical care, unless documentation of medical necessity for the physician’s office visit is submitted.

Payment for nurse-midwife services is made to the group with whom the nurse-midwife has a practice agreement; the group is then responsible for payment to the nurse-midwife. Payment for nurse-midwife services is made at the lower of -

1. The provider's submitted charge; or
2. The Medicaid allowable amount for the procedure code billed.

Claims for nurse-midwife services must be submitted on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). NMAP covers prenatal care, delivery, and post-partum care as a "package" service. Auxiliary services, such as pre-natal classes and home visits, are not paid as separate line items.
18-004.43 Nurse-Practitioner Services: The Nebraska Medical Assistance Program covers nurse-practitioner services under the following guidelines:

To participate in the Nebraska Medical Assistance Program, the nurse-practitioner must be certified by the Nebraska Department of Health and Human Services Regulation and Licensure. The practice agreement between the nurse-practitioner and the physician must be on file with the Nebraska Department of Health and Human Services Regulation and Licensure. The nurse-practitioner is approved for enrollment under a group provider agreement with the physician with whom s/he has a practice agreement.

NMAP covers nursing assessments as nurse-practitioner services. The services must be medically necessary. A nursing assessment includes the physical and psychological status of individuals and families by means of health history, and physical examinations as needed for the physician to establish diagnosis and institute treatment of a physical condition. The initial medical diagnosis and institution of a plan of therapy or referral may also be covered within the nurse-practitioner's area of specialization.

The Nebraska Medical Assistance Program does not cover any other services provided by nurse-practitioners.

Payment for nurse-practitioner services is made at the lower of -

1. The provider's submitted charge; or
2. The Medicaid allowable amount for the procedure code billed.

Claims for nurse-practitioner services must be submitted on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) according to claim submission instructions in the Appendix of this Title.
18-004.43A Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners: For services provided on or after July 1, 1990, NMAP covers services provided by certified pediatric nurse practitioners and certified family nurse practitioners under the following guidelines.

To participate in the Nebraska Medical Assistance Program, the certified pediatric nurse practitioner or certified family nurse practitioner must be certified by the Department of Health and Human Services Regulation and Licensure. The practice agreement between the certified pediatric nurse practitioner or certified family nurse practitioner must be on file with the Department of Health and Human Services Regulation and Licensure. The certified pediatric nurse practitioner or certified family nurse practitioner is approved for enrollment in NMAP under an independent provider agreement or the provider agreement of the physician with whom s/he has a practice agreement.

18-004.43A1 Standards for Certified Pediatric Nurse Practitioners: A certified pediatric nurse practitioner (CPNP) is a registered professional nurse who must -

1. Be currently licensed to practice as a registered professional nurse in the state in which the services are provided;
2. Meet the applicable state requirements for qualification of pediatric nurse practitioners, or nurse practitioners generally in the state in which the services are provided; and
3. Be currently certified as a pediatric nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates.

18-004.43A2 Standards for Certified Family Nurse Practitioners: A certified family nurse practitioner (CFNP) is a registered professional nurse who must -

1. Be currently licensed to practice as a registered professional nurse in the state in which the services are provided;
2. Meet the applicable state requirements for qualification of family nurse practitioners, or nurse practitioners generally in the state in which services are provided; and
3. Be currently certified as a family nurse practitioner by the American Nurses' Association.
18-004.43A3  Payment for Services Provided by Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners: NMAP covers services of CPNP’s and CFNP’s to the extent that they are legally authorized to practice in Nebraska.

Payment to CPNP’s and CFNP’s is made to the nurse practitioner or to the physician with whom the nurse practitioner has a practice agreement. If payment is made to the physician, the physician is then responsible for payment to the nurse practitioner. Payment for CPNP or CFNP services is made at the lower of -

1. The provider’s submitted charge; or
2. A percentage, determined by the Department, of the amount allowable under the Nebraska Medicaid Practitioner Fee Schedule if the service was provided by a physician.

Claims for CPNP and CFNP services must be submitted on Form CMS-1500 according to instructions in 471-000-62 or on the appropriate electronic transaction (see Claim Submission Table at 471-000-49).
18-004.44 Infant Apnea Monitors: NMAP covers rental of home infant apnea monitors for infants with medical conditions that require monitoring due to a specific medical diagnosis only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent/caregiver training must occur before placement of infant apnea monitor. Parent/caregiver training is not reimbursed as a service separate from infant apnea monitor rental.

18-004.44A Medical Guidelines for the Placement of Home Infant Apnea Monitors: NMAP covers home infant apnea monitoring services for infants who meet one of the following criteria. NMAP defines infancy as birth through completion of one year of age.

1. Infants with one or more apparent life-threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking, or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hypoventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants of substance-abusing mothers, or infants with less severe ALTE's.

18-004.44A2 Removing the Infant from the Monitor: Criteria for removing infants from home infant apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when ALTE infants have had two-three months free of significant alarms or apnea where vigorous stimulation or resuscitation was not needed. Evaluating the infant's ability to tolerate stress (e.g., immunizations, illness) during this time is advisable.

18-004.44C Approval of Home Infant Apnea Service Providers: NMAP covers rental of home infant apnea monitors and related supplies only from approved providers. To ensure all home apnea monitoring needs of infants are met, the Department requires the development of a home infant apnea monitor "Coordination Plan." The "Coordination Plan is not an individual patient plan; it is an overall program outline for the delivery of home apnea monitoring services. The "Coordination Plan" must be submitted to the Medicaid Division for approval before providing home infant apnea monitor and monitor supplies.

Note: Physicians may not bill for rental of apnea monitoring equipment or related supplies.
18-004.44D  Documentation Required After Initial Rental Period:  Monitor rental exceeding the original two-month prescription period requires that an updated physician's narrative report of patient progress and a statement of continued need accompany the claim.  A new progress report is required every two months.  The report must include -

1.  The number of apnea episodes during the previous prescription period;
2.  The results of any tests performed during the previous prescription period;
3.  Additional length of time needed; and
4.  Any additional information the physician may wish to provide.

18-004.44E  Limitations on Coverage of Apnea Monitor Equipment and Supplies:  NMAP does not cover monitors that do not use rechargeable batteries.

NMAP does not make separate payment for remote alarms.  If provided, payment for a remote alarm is included in the monitor rental.

Apnea monitor belts, lead wires, and reusable electrodes are covered for rented apnea monitors.

18-004.44E1  Pneumocardiograms:  Pneumocardiograms are covered only when physician ordered to determine when the infant may be removed from the monitor.  Payment for rental of an ECG/respirator recorder includes all accessories required to obtain a valid pneumocardiogram.  Payment for durable medical equipment does not include analysis and interpretation of tests.  This service must be billed by the physician performing the service.
18-004.45 Home Phototherapy: NMAP covers rental of home phototherapy (bilirubin) equipment for infants who require phototherapy when neonatal hyperbilirubinemia is the infant's sole clinical problem and only if prescribed by and used under the supervision of a physician. Prior authorization is not required for this service.

18-004.45A Medical Guidelines for the Placement of Home Phototherapy Equipment: NMAP recognizes the Nebraska Chapter of the American Academy of Pediatric's Standard of Care for home phototherapy. Home phototherapy services will be covered when the following conditions are met:

1. Infant evaluation by the physician and parent/caregiver training occurs before placement of equipment;
2. Documentation must be available with the supplier to show that -
   a. The physician certifies that the infant's condition meets the medical criteria outlined below and that the parent/caregiver is capable of administering home phototherapy; and
   b. The provider certifies that the parent/caregiver has been adequately trained and consent forms used by the provider have been signed; and
3. The infant's medical condition meets the following criteria:
   a. Greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gms (5 lbs);
   b. Greater than 48 hours of age;
   c. Bilirubin levels at initiation of phototherapy (greater than 48 hours of age) are 14-18 mgs per deciliter;
   d. Direct bilirubin level less than 2 mgs per deciliter;
   e. History and physical assessment (if the service begins immediately upon discharge from the hospital, the newborn discharge exam will suffice); and
   f. Required laboratory studies to include CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin (additional laboratory data may be requested at physician's discretion). At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

18-004.45B Discontinuing Home Phototherapy: Home phototherapy services will not be covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.
18-004.45C Approval of Home Phototherapy Providers: NMAP covers rental of home phototherapy equipment provided by approved providers. Physicians will not be approved as home phototherapy providers.

18-004.45D Documentation Required after Initial Rental Period: Home phototherapy services exceeding a three-day period require a physician's narrative report of patient progress and statement of continued need submitted with the claim.

18-004.45E Limitations on Coverage of Home Phototherapy Services: Payment for home phototherapy services does not include physician's professional services or laboratory and radiology services related to home phototherapy. These services must be billed by the physician or laboratory performing the service.

18-004.46 Ambulatory Uterine Monitors: NMAP covers rental of ambulatory uterine monitors. The monitor must be prescribed by and used under the supervision of a physician and provided by a medical supplier. Prior authorization is not required for this service.

18-004.46A Medical Guidelines for the Placement of Ambulatory Uterine Monitors: Ambulatory uterine monitors will be covered when the following conditions are met:

1. Evaluation by the physician and training on use of the monitor occurs prior to placement of the monitor;
2. Documentation must be available with the supplier to show that:
   a. The physician certifies that the client meets the medical criteria outlined below; and
   b. The provider certifies that the client has been adequately trained; and
3. The client must be at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy. The pregnancy must be greater than 20 weeks gestation and the client must meet one of the medical conditions listed below:
   a. Recent preterm labor with hospitalization and discharge on tocolytic therapy;
   b. Multiple gestation;
   c. History of preterm delivery;
   d. Anomalies of the uterus;
   e. Incompetent cervix;
   f. Previous cone biopsy;
   g. Polyhydramnios; or
   h. Diethylstilbestrol exposure.

Others at high risk for preterm labor and delivery may be covered for this service upon approval by the Department's Medical Director through written communication from the client's physician (preferably in consultation with a perinatologist).

18-004.46B Discontinuing the Monitor: Ambulatory uterine monitors will not be covered after completion of the 36th week of pregnancy.

18-004.46C Approval of Ambulatory Uterine Monitor Providers: NMAP covers rental of ambulatory uterine monitors provided by approved providers. Physicians are not approved as providers of ambulatory uterine monitors.
18-004.46D Limitations on Coverage of Ambulatory Uterine Monitors: NMAP's allowable fee includes all equipment, supplies, and services necessary for the effective use of the monitor. This does not include medications or physician's professional services. Rental is allowable only when the client is at home and appropriately using the monitor.

18-004.47 Services of Certified Registered Nurse Anesthetists (CRNA's): The Nebraska Medical Assistance Program (NMAP) covers the services of CRNA's under the following conditions.

18-004.47A Provider Participation: A certified registered nurse anesthetist (CRNA) is a registered nurse who is licensed by the Department of Health and Human Services Regulation and Licensure and is currently certified by the Council on Certification of Nurse Anesthetists or Council on Recertification of Nurse Anesthetist, or has graduated since August 1987 from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

To participate in NMAP, the CRNA shall submit a completed Form MC-19, "Medical Assistance Provider Agreement," with a copy of his/her credentials attached, to the Nebraska Department of Health and Human Services Finance and Support for enrollment in NMAP. NMAP shall verify eligibility/credentials before initial enrollment.

18-004.47A1 Provider Numbers: CRNA's may bill NMAP directly for their services or have payment made to an employer or entity under which they have a contract (i.e., physician, hospital, or ambulatory surgical center (ASC)). When the provider is enrolled, NMAP will issue a provider number to the CRNA. A separate Form MC-19 and provider number is required for each of the following:

1. An individual CRNA billing directly (one provider number);
2. A group of CRNA's billing directly (one provider number to cover all in the group); or
3. A physician, hospital, or ambulatory surgical center (ASC) who is billing for the services of CRNA's who are employed the physician, hospital, or ASC (one provider number to cover all employees).

18-004.47B Claims for CRNA Services: Claims for CRNA services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Exception: Rural hospitals that have been exempted by their Medicare fiscal intermediary for CRNA billing shall follow the Medicare billing requirements.

When anesthesia services are provided by an anesthesiologist and a CRNA at the same time, NMAP will recognize for payment only those services provided by the anesthesiologist.

NMAP does not make additional reimbursement for emergency and risk factors.

When multiple surgical procedures are performed at the same time, the CRNA shall bill only for the major procedure. NMAP does not make payment for CRNA services for secondary procedures.
18-004.47C Payment for CRNA Services: These services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.48 and 18-004.49 (Reserved)
18-004.50 Feeding and Swallowing Clinic Services: The Nebraska Medical Assistance Program covers feeding and swallowing clinic services under the following conditions.

This service is covered for those clients with medical conditions that make feeding and swallowing difficult (dysphagia). The service is covered when the client is referred by a physician for a medical evaluation. The purpose of the evaluation is to assess the client's current status and potential for improvement and to develop a plan of care for the client.

The initial evaluation is performed by an interdisciplinary team. The interdisciplinary team must, at a minimum, include, but is not limited to, a nurse, occupational therapist, speech pathologist, nutritionist, psychologist, and radiologist. The team must be under the direction of a physician.

Follow-up visits must be available in a frequency adequate to meet patient needs and program objectives.

18-004.50A Provider Enrollment: The provider shall submit a completed Form MC-19 along with a program overview that demonstrates the following components of service are available within the program:

1. Interdisciplinary team evaluation which provides information to team members on the patient's medical status and nutrition/diet status and also addresses feeding and behavioral concerns. In the process of the interdisciplinary team evaluation, the team must review and consider information from other available resources, e.g., attending/referring physician, nursing home, school;
2. Assessment by the occupational therapist of the client's tone and posture to determine seating/positioning for feeding and for the videofluoroscopy procedure;
3. Examination by the speech pathologist to assess the client's oral structures and clinical swallowing evaluation;
4. A videoflouroscopy (swallow study) to determine conditions that are most favorable for a safe, efficient swallow and management of feeding problems.
5. Assessment of oral motor function (i.e., use of lips, jaws, cheeks, and tongue) and feeding behaviors. Depending on the needs of the client, some or all of the team members may be involved in this component. This assessment includes presentation of a variety of amounts and types of foods and liquids to the clients to provide additional information used to establish therapeutic intervention;
6. Conference by team members to review findings, establish priorities, and coordinate treatment and follow-up recommendations; and
7. Presentation of plan of care to the client/family, including instruction, demonstration, and written recommendations for feeding procedures at home and in other environments. This may include school, nursing home, or others involved in the patient's care.

After the initial visit, the team formulates a formal written report and sends copies to the client/family, the referring physician, and others designated by the client/family and/or by the Department.

The team contacts, by telephone, the referring physician and, if appropriate, other medical professionals, to provide immediate feedback to the team on primary findings and recommendations.

18-004.50B Follow-Up Calls: Follow-up telephone call are made after the initial evaluation and are included in the cost of the evaluation, as follows:

1. Within 48 hours after the evaluation, a team member calls the client/family to answer questions and provide clarification, if needed of any information presented during the initial visit.
2. Two to four weeks after the initial visit, a follow-up call is made to ask about progress and/or problems in following the team recommendations;
3. Ongoing telephone communication is maintained with the client/family and/or referring physician to facilitate implementation of the team recommendations.

18-004.50C Billing and Payment: NMAP defines the services as follows:

**Swallowing disorders assessment, comprehensive:** This includes, at a minimum, comprehensive evaluation by the occupational therapist, speech pathologist, nurse, and nutritionist. The need for a psychology evaluation is determined by intake information; the psychology evaluation is billed separately.
Swallowing disorder assessment, extended: This includes, at a minimum, a comprehensive evaluation by the occupational therapist and extended evaluations by the speech pathologist, nurse, and nutritionist. The need for a psychology evaluation is determined by intake information; the psychology evaluation is billed separately.

Swallowing disorder assessment, brief: The brief assessment includes approximately two hours of time for the occupational therapist, speech pathologist, and nutritionist.

Follow-up visit, brief: This includes a visit with two or more team members.

Follow-up visit, extended: This includes a visit which involves four or more team members.

The team’s services are billed under the physician’s provider number on Form CMS-1500 or the standard electronic Health Care Claim: Professional Transaction (ASC C12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

The physician services are billed under appropriate CPT codes.

18-004.51 Comprehensive Interdisciplinary Treatment for a Severe Feeding Disorder: Comprehensive interdisciplinary treatment means the collaboration of medicine, psychology, nutrition science, speech therapy, occupational therapy, social work, and other appropriate medical and behavioral disciplines in an integrated program. Nebraska Medicaid may cover comprehensive interdisciplinary treatment for an infant or child with a severe feeding disorder that impacts the infant’s or child’s ability to consume sufficient nutrition orally to maintain adequate growth or weight.

18-004.51A Prior Authorization: Prior authorization is required of all services before the services are provided.

The requesting physician shall submit a request to the Department 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) or by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
P.O. Box 95026
Lincoln, NE 68509-5026
Fax telephone number: (402) 471-9092
The request must include the following information or explanation as appropriate to the case:

1. A referral from the primary care physician that includes current appropriate medical evaluations or treatment plans;
2. Medical records for the last year that include height and weight measurements; and
3. Any records from feeding and swallowing clinic evaluations and other therapeutic interventions that have occurred.

18-004.51B Service Definitions: Nebraska Medicaid defines the services as follows:

Day treatment is defined as daily therapy (M-F) from approximately 8:30 am to 5 pm.

Outpatient is defined as therapy 1 to 2 times per week for 1-3 hours per day.

18-004.51C Billing: Claims for the following services must be submitted by using the paper Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837)

18-004.51D Payment Rates

18-004.51D1 Pediatric Feeding Disorder Clinic Intensive Day Treatment: Reimbursement for pediatric feeding disorder clinic intensive day treatment for medically necessary services will be a bundled rate based on the sum of the fee scheduled amounts for covered services provided by Medicaid enrolled licensed practitioners.

18-004.51D2 Pediatric Feeding Disorder Clinic Outpatient Treatment: Reimbursement for pediatric feeding disorder clinic outpatient treatment for medically necessary services will be based on the appropriate fee schedule amount for a physician consultation for covered services provided by Medicaid enrolled licensed practitioners.
Tobacco Cessation: Medicaid covers tobacco cessation services as practitioner and pharmacy services under the following conditions:

1. Up to two tobacco cessation sessions may be covered in a 12-month period. A session is defined as medical encounters and drug products as listed in items 2 and 3 below. Client access to the Nebraska Tobacco Free Quitline will be unlimited.

2. Practitioner Office Visits:
   a. Clients must see their medical care provider (physician/mid-level practitioner) for evaluation particularly for any contraindications for drug products and to obtain prescription(s) if tobacco cessation products are needed.
   b. (1) In addition to the evaluation under item 2a, a total of four tobacco cessation counseling visits with a medical care provider or tobacco cessation counselor (see 471 NAC 16-002.04) are covered for each tobacco cessation session. This may be a combination of intermediate or intensive tobacco cessation counseling visits.
   (2) Tobacco cessation counseling provided by a Tobacco Cessation counselor must be ordered by the physician/mid-level practitioner.

3. Tobacco cessation products are covered by Medicaid as a pharmacy service (see 471 NAC 16-000) for those clients 18 years of age or older who require that particular assistance.
   a. Coverage of products used for tobacco cessation is limited to a maximum 90 days supply in one tobacco cessation session. The coverage period is limited to 90 consecutive calendar days, beginning with the date the first prescription for the products is dispensed.
   b. Tobacco cessation products will only be covered when clients are currently enrolled with and actively participating in the Nebraska Tobacco Free Quitline. Disenrollment or lack of active participation in the Nebraska Tobacco Free Quitline will result in discontinuation of Medicaid coverage of drug products.

4. Nebraska Tobacco Free Quitline: For coverage of tobacco cessation products, clients must be enrolled in and active with the Nebraska Tobacco Free Quitline. Referral to the Quitline may be made by a medical professional (physician/mid-level practitioner) or a self referral.
18-006 Payment for Physician Services: Nebraska Medicaid pays for covered physician services, except clinical laboratory services, at the lower of

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).
3. Exception: The Director of the Division of Medicaid and Long-Term Care or designee may enter into an agreement with an out-of-state provider for a rate that exceeds the rate according to the Nebraska Medicaid Practitioner Fee Schedule only when the Medical Director of the Division has determined that:
   a. The client requires specialized services that are not available in Nebraska; and
   b. No other source of the specialized service can be found.

Reimbursement for services provided by physicians and non-physician care providers is subject to the site-of-service payment adjustment. Medicaid applies a site of service differential that reduces the fee schedule amount for specific CPT/HCPCS codes when the service is provided in a facility setting. Based on the Medicare differential, Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site of service. For the list of applicable CPT/HCPCS codes, refer to NAC 471-000-541.

Payment for clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization is made at the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare. The Fee Schedule may be revised in accordance with 18-006.01.

Non-Payment of Other Provider Preventable Conditions (OPPCs): Effective on or after the effective date of this regulation for physician and non-physician provider claims, payment will be denied for the following OPPCs:

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

HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518).

18-006.01 Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of the revisions and their effective dates.
**18-006.02 Supplemental Payments:** Supplemental payments will be made for services provided by practitioners who are acting in the capacity of an employee or contractor of the University of Nebraska Medical Center or its affiliated medical practices; UNMC Physicians and Nebraska Pediatric Practice, Inc. These payments are made in addition to payments otherwise provided under the state plan to practitioners that qualify for such payments. The supplemental payment applies to services provided by the following practitioners:

- Physicians (MD and DO)
- Advanced Nurse Practitioners
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Audiologists
- Optometrists
- Licensed Independent Mental Health Practitioners
- Psychologists

All services eligible for supplemental payments are billed under the federal employer number for the public entity.

For practitioners qualifying under this section, a supplemental payment will be made. The payment amount will be the difference between payments otherwise made to these practitioners and the average rate paid for the services by commercial insurers. The payment amounts are determined by:

1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the provider’s contracted rates with the commercial insurers for each procedure code from an actual year’s data, utilizing the rate in effect in January for payments during the calendar year.
2. Multiplying the total number of Medicaid claims paid per procedure by the average commercial payment rate for each procedure to establish the estimated commercial payments made for these services.
3. Subtracting the initial fee-for-service Medicaid payments and all Third Party Liability payments already made for these services to establish the supplemental payment amount. All claims where Medicare is the primary payor will be excluded from the supplemental payment methodology.
4. Calculating the supplemental payments 90 days after the end of each fiscal year quarter. For each fiscal quarter, the public entity will provide a listing of the identification numbers for their practitioner/practitioner groups that are eligible for the supplemental payment to the Department. The Department will generate a report, which includes the identification numbers and utilization data for the affected practitioners/practitioner groups. The amount due is paid to the University of Nebraska Medical Center. In no instance is the sum of the base payment and supplemental payment greater than the practitioner's initial charge for services rendered.
5. Paying initial fee-for-service payments made under this section on a claims-specific basis through the Department’s claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents the final payment, will be made in four (4) quarterly payments.

With the exception of administrative costs incurred by the single state agency that are associated with calculating and implementing the adjustments, the entire benefit from the supplemental payments will be retained by the University of Nebraska Medical Center as an offset to incurred public expenditures.
18-007 Billing Requirements: Providers must bill NMAP on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for all services including HEALTHCHECK (EPSDT) exams, and EPSDT-associated services.

Physicians’ services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837); physicians’ services must not be billed by a hospital on the hospital claim form (Form CMS-1450 (UB-04) or electronic format).

The physician or the physician’s authorized agent must approve and date each paper claim. Approval of paper claims is indicated by the handwritten signature, signature stamp, or computer-generated signature of the physician or authorized agent.

When a computer-encoded document or electronic transaction is used, the Department may request the provider’s source input documentation from the provider for input verification and signature requirements.

The physician or the physician’s authorized agent must enter the physician’s usual and customary charge for each procedure code on the claim.

18-007.01 Procedure Codes: Physicians must use HCPCS procedure codes when submitting claims to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

1. **Level 1**: The codes contained in the most recently published edition of the American Medical Association’s Current Procedural Terminology (CPT); and
2. **Level 2**: Federally-defined alpha-numeric codes.
18-008 PHYSICIAN SERVICES FOR PATIENT-CENTERED MEDICAL HOME PILOT: This is a time-limited pilot as defined in Neb. Rev. Stat Sections 68-957 to 68-961. Participation is limited to the practices selected by the Department.

18-008.01 Definition of Patient-Centered Medical Home: Patient-Centered Medical Home means a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team. This team will provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and coordinate the patient’s health care needs across the health care system in order to improve quality, safety, access, and health outcomes in a cost effective manner.

Practices for participation in the pilot will be limited to General Practice, Internal Medicine, Family Practice, and Pediatrics.

18-008.01A Service Components: The medical home is comprised of the following components:

1. Care coordination: One or more Medical Home staff are dedicated to coordinating the care of the patients. Care is coordinated across all facets of the health care system. Information technology is utilized to support patient care.

2. Accessibility: The medical home offers access to care outside traditional business hours and utilizes systems of care for access to the team 24 hours/day, 7 days/week.

3. Patient Engagement: Patients are encouraged to take responsibility for their health care through a clear health plan, joint decision making, and patient education provided by the medical home.

4. Quality Improvement: Members of the medical home team assume responsibility for continuous quality improvement through the use of data and evidence-based best practices.

18-008.02 Provider Participation: Practices selected by the Department to participate in the Medical Home Pilot shall meet the standards listed in the medical home agreement.

18-008.03 Payment

18-008.03A Fee-for-Service (FFS): The Medical Home provider will be reimbursed for all allowable Medicaid services. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule as described in 471 NAC 18-006.
**18-008.03B Incentive Payment**: The Medical Home provider will receive a per member per month and may receive an enhanced fee-for-service when certain standards are met.

**18-008.03B1 Per Member Per Month (PMPM) Payment**: For patient care coordination and administration expenses, the pilot Medical Home will receive an initial PMPM payment. This payment will begin once the agreement is signed; then the Medical Home must achieve minimum standards within six months. Once the minimum standards are met, the PMPM payment will be increased.

If the minimum standards are not met within six months, the PMPM payment will be suspended until the minimum standards have been met.

**18-008.03B1a Client Attribution Method**: The client will not be selecting a provider nor will s/he be assigned a provider by the Department. The determination of client assignment for the PMPM will be done through an attribution methodology that recognizes the client’s choice of a provider as follows:

1. There will be a look-back at paid claims for the past 12 months for the Medical Home for selected Evaluation and Management and Preventive Visit codes for New and Established Patients.

2. If the client is currently Medicaid eligible, the Medical Home with the most visits with a specific client will receive the attribution and the PMPM payment and enhanced FFS (if applicable) for that client for the month. If there is a tie between pilot Medical Homes, the client will be attributed to the practice that provided care for the last/most recent visit in the 12-month period.

3. The attribution will be re-assessed on a monthly basis for a rolling twelve months (i.e. each month, the oldest month will be dropped and the newest month added).

4. PMPM payment will be paid retrospectively (example: on December 31st based on claims history, Medical Home A will receive an attribution of X number of clients and will be paid for that number of clients in January).
18-008.03B2 Enhanced Fee-for-Services (EFFS) Payment: Upon successful completion of minimum standards, the pilot Medical Home will have the option of continuing to transform the Medical Home to meet the advanced standards. Once the advanced standards are met, the Medical Home will receive an additional enhanced FFS payment on selected Evaluation and Management and Preventive Visit codes for Established Patients.

18-008.04 Billing: The allowable Medicaid services are billed under the Medical Home provider number on Form CMS-1500 or the standard electronic Health Care Claim: Professional Transaction (ASC C12N 837). The physician services are billed under appropriate CPT codes.

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518).

18-008.04A Billing for Medical Home Pilot Per-Member-Per-Month (PMPM) and for Enhanced Fee-for-Services (EFFS): The PMPM and EFFS will be automatically processed by the Department. The Medical Home does not need to submit a separate claim for either.
CHAPTER 19-000  PODIATRY SERVICES

19-001 Definitions

Podiatry: The diagnosis or medical, physical, or surgical treatment of the ailments of the human foot, ankle, and related governing structures except (1) the amputation of the forefoot, (2) the general medical treatment of any systemic disease causing manifestations in the foot, and (3) the administration of anesthetics other than local.

19-002 Provider Requirements

19-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of podiatry services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in 471 NAC Chapter 19, the individual provider participation requirements in 471 NAC Chapter 19 shall govern.

19-002.02 Service Specific Provider Requirements: Podiatrists must be licensed by the Nebraska Department of Health and Human Services, Division of Public Health. If podiatry services are provided outside Nebraska, the podiatrist must be licensed in that state.

19-002.02A Provider Agreement: The podiatrist shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

19-003 Service Requirements

19-003.01 General Requirements

19-003.01A Medical Necessity: Podiatry services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A.

19-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

19-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.
19-003.02 Covered Services: Medicaid covers medically necessary podiatry services within the scope of the podiatrist’s licensure and within program guidelines (471 NAC 19-003.02).

19-003.02A Routine Foot Care: Routine foot care includes:
   i. Cutting or removal of corns or calluses;
   ii. Trimming of nails;
   iii. Other hygienic and preventive maintenance care or debridement, such as cleaning and soaking the feet, and the use of skin creams to maintain the skin tone; and,
   iv. Any services performed in the absence of localized illness, injury, or symptoms involving the foot.

19-003.02A1 Frequency Limitations: Coverage of routine foot care is limited to:
   a. One treatment every 90 days for non-ambulatory clients; or,
   b. One treatment every 30 days for ambulatory clients.

19-003.02A2 Evaluation and Management (E&M) Services: E&M services are not covered in addition to routine foot care (such as debridement or reduction of nails, corns, and calluses, etc.) on the same date of service, except:
   a. New patient visits; or
   b. When another separately identifiable service or procedure provided on the same date is documented in the medical record.

19-003.02B Surgery: Surgical procedures performed by podiatrists must be in accordance with the provisions of Neb. Rev. Stat. §38-3011.

19-003.02B1 Site of Service Limitation: Medicaid accepts Medicare’s determination of surgical procedures that are primarily performed in office settings.

19-003.02B2 Sterile Surgical Trays: Medicaid covers one sterile surgical tray for each surgical procedure the podiatrist performs on a Medicaid client, in his/her office.

19-003.02B3 Assistant Surgery: Medicaid covers an assistant surgeon only for surgical procedures that are identified by CMS/AMA HCPCS coding as warranting an assistant surgeon.

19-003.02C Supportive Devices for the Feet: Medicaid covers orthopedic footwear, shoe corrections, orthotic devices and similar supportive devices for the feet if medically necessary for the client's condition. In addition to coverage as outlined herein, please see 471 NAC 7-013.

19-003.02D Clinical Laboratory Services: Medicaid covers clinical laboratory services that are:
   1. Medically Necessary;
   2. Provided in a podiatrist's, or group of podiatrists', private office; and,
   3. Provided or supervised by the podiatrist(s).

19-003.02E Injections: Medicaid covers intramuscular and subcutaneous injections at the cost of the medication plus an injection fee.
19-003.02F Supplies: Medicaid may cover medically necessary supplies that are used during the course of treatment and require application by the podiatrist (e.g., splints, casts and other devices used in the treatment of fractures, etc.). Routine supplies, and supplies that are considered incidental to the professional service (e.g., application of surgical dressings) are not covered.

19-004 Billing and Payment for Podiatry Services

19-004.01 Billing

19-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in 471 NAC Chapter 19, the billing requirements in 471 NAC Chapter 19 shall govern.

19-004.01B Specific Billing Requirements

19-004.01B1 Billing Instructions: Providers shall bill Medicaid, using the appropriate claim form or electronic format (see Claim Submission Table at Appendix 471-000-49), and in accordance with the billing instructions included in Appendix 471-000-63.

19-004.02 Payment

19-004.02A General Payment Requirements: Medicaid will reimburse provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 19, the payment regulations in 471 NAC Chapter 19 shall govern.

19-004.02B Specific Payment Requirements

19-004.02B1 Reimbursement: Medicaid pays for covered podiatry services in an amount equal to the lesser of:
   a. The provider's submitted charge; and
   b. The allowable amount for that procedure code in the Medicaid Practitioner Fee Schedule (471-000-519) in effect for that date of service.

19-004.02B2 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471-000-70.

19-004.02B3 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.

19-004.02B4 Payment for Surgery: Payment for surgeries is as follows:
   a. Surgical procedures are arranged in descending order according to Medicaid's allowable charges. The major procedure is paid at 100 percent of the allowable charge; and
   b. Subsequent procedures are paid at 50 percent of the allowable charge.
Except for the initial office visit, payment for major surgical procedures includes office visits on the day of surgery and 14 days of post-operative care. Medicaid follows the surgery guidelines in the American Medical Association’s Current Procedural Terminology (CPT).

Payment for surgical procedures that are primarily performed in office settings is reduced by 12% when performed in hospital outpatient settings (including emergency departments).

19-004.02B5 Sterile Surgical Trays: Payment for a sterile surgical tray includes surgical instruments (routine or special), office operating room cost, sutures, supplies, items used to prepare a sterile field for the surgical procedure, and the sterilization and maintenance of these items.

19-004.02B6 Supportive Devices for the Feet: Payment for custom orthotic devices which require impression casting by the podiatrist includes:
   a. Fitting;
   b. Cost of parts and labor;
   c. Repairs due to normal wear and tear within 90 days of the date dispensed; and,
   d. Adjustments made when fitting and for 90 days from the date dispensed.
      i. Adjustments necessitated by changes in the client’s medical condition, or the client’s functional abilities, are reimbursed separately.

19-002.04B7 Clinical Laboratory Services: Payment for specimens obtained in the podiatrist’s office and sent to an independent clinical lab or hospital for processing must be claimed by the facility performing the tests. The Department does not reimburse the podiatrist for handling specimens or processing or interpreting tests performed outside the podiatrist’s office.
20-000  PSYCHIATRIC SERVICES FOR INDIVIDUALS AGE 21 AND OLDER

20-001  General Requirements for Psychiatric Services: Effective July 1, 1995, the requirements of this chapter apply to all psychiatric services for individuals age 21 and older provided under the Nebraska Medical Assistance Program (NMAP).

Mental health and substance abuse services (MH/SA) are provided as a managed care benefit for all Nebraska Medicaid Managed Care (NMMCP) clients. The benefit includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized.

20-001.01  Philosophy of Care: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. More restrictive levels of care will be used only when all other resources have been explored and deemed to be inappropriate.

20-001.02  Non-Discrimination: The Department believes that each person, regardless of race, color, sex, age, religion, national origin, disability, sexual orientation, or marital status possesses inherent worth and value. The Department expects services to be provided in a way that shows respect and support for such diversity. Providers must be aware of the issues which may arise and ask for consultation or make referrals as needed.

20-001.03  Family of Origin Component: Care must address family concerns and, whenever possible, involve the family in treatment planning, therapy, and transition/discharge planning. Family may include biological, step, foster, or adoptive parents; siblings or half siblings; and extended family members, as appropriate. Family involvement, or lack thereof, must be documented in the clinical record. For adults who choose not to have family members involved or for whom the treating professional deems family involvement inappropriate or harmful, that information must be documented in the medical record. Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.
20-001.04 Community-Based Care: Care must be community-based and, when appropriate, must involve a representative from the client's community support system. This may include areas such as education, social services, law enforcement, religion, medical, and other mental health or substance abuse professionals. Community involvement must be documented in the clinical record. This documentation must include any lack of cooperation or resistance from the community support system.

20-001.05 Developmentally Appropriate Care: Care must address the client's biological, psychological, and social development. Therapeutic interventions must be congruent with the findings of the developmental level of the client, based on comprehensive psychiatric and psychological assessments.

20-001.06 Culturally Competent Care: Providers of psychiatric services for individuals age 20 and over must be culturally competent. This includes awareness, acceptance, and respect of differences and continuing self-assessment regarding culture. Cultural competence also includes careful attention to the dynamics of differences and how they affect interactions, assumptions, and the delivery of services. Providers also demonstrate cultural competence through continuous expansion of cultural knowledge and resources through training, readings, etc., and by providing a variety of adaptations to service models in order to meet the needs of different cultural populations.

Culturally competent providers hire unbiased employees, seek advice and consultation from the minority community, and actively decide whether or not they are capable of providing services to clients from other cultures. They provide support for staff to become comfortable working in cross-cultural situations and understand the interplay between policy and practice and are committed to policies that enhance services to diverse clientele.

20-001.07 Dually Diagnosed Clients: The treatment provider shall incorporate the needs of the "dually diagnosed" client and provide active treatment for clients with concurrent or secondary complicating problems. The "dually diagnosed" clients may have problems such as substance abuse, eating disorder symptoms, developmental delays, or mental retardation. Dual diagnosis treatment is the simultaneous and integrated treatment of coexisting disorders.

20-001.08 Coordinated Services: If a client is receiving services from more than one psychiatric provider, the providers must assure coordination of all services. That coordination must be documented in the client's medical record. Coordination of services is required as part of the overall treatment plan must be covered in one unified treatment plan, and is not billable as a separate service.
20-001.09 Provider Enrollment

20-001.09A Provider Agreement: A provider of psychiatric services for individuals age 21 and over shall complete Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. Specific requirements for each type of care are listed in the respective subpart. The provider must meet all of these standards in order to be enrolled with NMAP. The Department is the sole determiner of which providers are approved for participation in this program. The provider will be advised in writing when their participation is approved. (A separate application must be submitted for each particular service and each service will be approved separately.)

Refer to the Standards for Participation section in each subpart.

20-001.09B Provider Enrollment Status: The provider enrollment process allows for three types of provider enrollment status based on information from the provider and other sources. The Department shall notify the provider of the status assigned. The types of provider enrollment are -

1. Provisional status: A provider who has recently established services within this chapter or who is new to the NMAP will be enrolled with a provisional status. After a minimum of one year of services, the Department may choose to grant ongoing status to the provider.
   a. Grounds for terminating a provider agreement are further defined in 471 NAC 2-002.03, "Reasons for Sanctions."
   b. Providers may appeal the decision to terminate a provider enrollment. The appeal process is described in 471 NAC 2-003, "Provider Hearings."
2. Ongoing status: A provider may establish ongoing status after a minimum of one year of service within the Medicaid guidelines.
3. Probationary status: A provider may be placed on probationary status when there are deficiencies in meeting Medicaid guidelines or there are other concerns about the provider's program or practices. While on probationary status, a provider may be required to work with Medicaid staff to develop a corrective action plan. This plan shall be submitted to Medicaid staff for approval.
   a. Grounds for terminating a provider agreement are further defined in 471 NAC 2-002.03, "Reasons for Sanctions."
   b. Providers may appeal the decision to place a provider on probationary status. The appeal process is described in 471 NAC 2-003, "Provider Hearings."
   c. The probationary status will be evaluated by Medicaid staff on a frequency based on the situation. At these evaluations, a provider's enrollment may be terminated, placed on further probation, or returned to ongoing status. Providers may appeal these decisions as described in 471 NAC 2-003, "Provider Hearings."
d. If the deficiencies are not causing immediate jeopardy or compromising the safety of the clients, then the facility can continue to participate in Medicaid. A prohibition of new admissions may occur if:

1. There are allegations of abuse or neglect under investigation in relation to the program or its staff;
2. The quality of treatment is significantly compromised by the deficiencies; or
3. The provider is violating any laws, regulations, or code of ethics governing their program.

20-001.09C Updates: The provider shall send to the Department an update of the services provided in its facility and the current list of staff each year during the anniversary quarter of the provider's enrollment in Nebraska Medicaid as a provider of psychiatric services for individuals age 21 and over. This information shall also be sent to the Department if a provider makes changes in how they provide a service. These changes and updates must be indicated on Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement."

20-001.10 Out-of-State Services: See 471 NAC 1-002.01F. In addition, potential out-of-state providers of Chapter 20 services must have a specific plan of how they will meet the family and community requirements. This plan must be approved by the Department to become a provider of NMAP services.

20-001.11 Quality Assurance and Utilization Review: All providers participating in NMAP have agreed to provide services under the requirements of 471 NAC 2-001.03, Provider Agreements. If there is any question or concern about the quality of service being provided by an enrolled provider, the Department may perform quality assurance and utilization review activities, such as on-site visits, to verify the quality of service. If the provider or the services do not meet the standards of this chapter and the specific level of care, the provider may be subject to administrative sanctions under 471 NAC 2-002 ff. or denial of provider agreement for good cause under 471 NAC 2-001.02A. The Department may request a refund for all services not meeting Chapter 20 requirements.

If the clients are in immediate jeopardy, the sanctions may be imposed under 471 NAC 2-002.05 without a hearing.
20-001.12 Service Definitions: The following definitions of service apply within this chapter:

**Individual Psychotherapy:** A face-to-face treatment session between the client and the appropriate mental health professional for an acceptable primary psychiatric diagnosis. (No additional reimbursement is made for medication checks performed by a physician in the course of individual psychotherapy.)

**Group Psychotherapy:** A face-to-face treatment session, requiring professional expertise, between the client and the appropriate mental health professional in the context of a group setting of at least three and not more than twelve clients. Group psychotherapy must provide active treatment for a primary psychiatric diagnosis. NMAP does not cover: groups that are primarily supportive or educational in nature, or the services of a co-therapist.

**Family Assessment:** A comprehensive family assessment must be completed during the initiation of services. This must be completed by a mental health professional with training and experience in family systems.

**Family Psychotherapy:** A face-to-face treatment session, requiring professional expertise, between the client (identified patient), the nuclear and/or extended family, and the appropriate mental health professional. These services must focus on the family as a system and include a comprehensive family assessment. The specific objective of treatment must be to alter the family system to increase the functional level of the identified patient. This therapy must be provided with the appropriate family members and the identified patient. The focus of the services must be on systems within the family unit. Therapists of families with more than one provider must communicate with and coordinate services with any other provider for the family or individual family members. Coordination of services is required as part of the overall treatment plan and is not billable as a separate service. Duplicate or co-therapist services will not be reimbursed. The client must be eligible for NMAP and have an acceptable primary psychiatric diagnosis.

**Services of Psychiatric Resident Physicians:** Psychiatric resident physicians may provide psychotherapy services and medication checks when these services are directly supervised by the attending psychiatrist. The resident's supervising psychiatrist shall sign the Department approved treatment planning document for services provided by the resident physician. The resident physician may not supervise services of allied health therapists, licensed mental health practitioners, or qualified R.N.'s. Resident physician services must be billed using the appropriate CPT/HCPCS procedure codes.
Observation Room Services (23:59): When appropriate for brief crisis stabilization, outpatient hospital observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used as follows: An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services. NMAP covers observation room services under the following conditions:

1. Since this service has the potential to become an inpatient hospitalization, the claim will be reviewed according to the standards of care for inpatient hospitalization in 471 NAC 20-007;
2. If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed, and whether s/he remained in the hospital past midnight or the census-taking hour;
3. When the patient reaches 24 hours of continuous outpatient care, all inpatient–medical review prior-authorization requirements noted in 471 NAC 20-007 and 20-008 apply; and
4. The services must be billed as an outpatient hospital psychiatric service on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

20-001.13 Psychiatric Therapeutic Staff Standards: Psychiatric therapeutic staff for adult services shall meet the following requirements:

1. Supervising Practitioners: All psychiatric services must be provided under the supervision and direction of a supervising practitioner. The following are the professional designations of those who qualify as a supervising practitioner:
   a. Physician: Must be licensed as a physician by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency in the state in which s/he practices and must be enrolled with NMAP with a primary specialty of psychiatry.
   b. Licensed Psychologist: Must be a licensed psychologist by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices and must be enrolled with NMAP with a primary specialty of clinical psychology.
   c. Licensed Independent Mental Health Practitioners (LIMHP) (effective December 1, 2008 and after).
Definition and Practice of Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action. This includes, but is not limited to, review of treatment plan and progress notes, client specific case discussion, periodic assessments of the client (as defined in each section), and diagnosis, treatment intervention or issue specific discussion. The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment team. The critical involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview, the treatment plan, and the interventions provided.

The supervising practitioner (or their designated and qualified substitute) must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.

Supervisory contact may occur in a group setting.

Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.

Psychiatric resident physicians, physician assistants and Advanced Practice Registered Nurses may not supervise allied health therapists for Medicaid services.

Effective December 1, 2008, Licensed Independent Mental Health Practitioners may supervise other licensed practitioners.

The supervising practitioner shall periodically evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed.

2. Psychiatrically trained physician extenders may not supervise services in place of the physician, but may provide direct care as allowed by the scope of practice guidelines set by the Nebraska Department of Health and Human Services, Division of Public Health and the practice agreement of each individual. A copy of the practice agreement must be submitted at the time of application for enrollment.

3. Licensed Independent Mental Health Practitioners (LIMHP) may provide direct care as allowed by the scope of practice guidelines set by Nebraska Department of Health and Human Services, Division of Public Health.

4. Allied Health Therapists: All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under his/her supervision. All allied health therapists must have knowledge of the interactional systems within families.

   Allied health therapists include:
   a. Specially Licensed Psychologists: Persons who are specially licensed as psychologists through the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;
   b. Licensed Mental Health Practitioners: Persons who are licensed as mental health practitioners by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;
c. Provisionally Licensed Mental Health Practitioners: Practitioners who are licensed as a provisional mental health practitioner by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the State in which s/he practices.

d. Qualified Registered Nurse: A registered nurse (R.N., R.N. with Bachelor's, Masters, or Ph.D., or certification as a psychiatric clinical specialist or nurse practitioner by the American Nurse Association) who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;

e. Qualified Mental Health Professional/Masters Equivalent: A holder of a master's degree in a closely related field that is applicable to the bio/psycho/social sciences or to treatment for persons who are mentally ill and is actively pursuing licensure as a mental health practitioner as allowed by the Nebraska Department of Health and Human Services, Division of Public Health; or a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement.

5. Any Medicaid provider who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health and has a substantiated disciplinary action filed against the license that limits the provision of services will not be allowed to provide NMAP services. If a provider is licensed by another state, substantiated disciplinary action filed against that license that limits the provision of services will be cause for termination as an NMAP provider.

20-001.14 Payment Limitations: Payment for psychiatric services for individuals age 21 and older under NMAP is limited to payment for medically necessary psychiatric services for medically necessary primary psychiatric diagnoses.

NMAP does not pay for psychiatric services that are chronic or custodial. Psychiatric services may be covered when treating an acute exacerbation of a long-term or chronic condition. The provider shall document medical necessity and active treatment for each client. Documentation is kept in the client’s medical record.

20-001.15 Medical Necessity: Medically necessary services are services provided at an appropriate level of care which are based on documented clinical evaluations including a comprehensive diagnostic workup and supervising practitioner-ordered treatment.

Biopsychosocially necessary treatment interventions and supplies are those which are:

1. Consistent with the behavioral health condition and conducted with the treatment of the client as the primary concern;
2. Supported by sufficient evidence to draw conclusions about the treatment intervention's effects of behavioral health outcomes;
3. Supported by evidence demonstrating the treatment intervention can be expected to produce its intended effects on behavioral health outcomes;
4. Supported by evidence demonstrating the intervention's intended beneficial effects on behavioral health outcomes outweigh its expected harmful effects;
5. Cost effective in addressing the behavioral health outcome;
6. Determined by the presentation of behavioral health conditions, not necessarily by the credentials of the service provider;
7. Not primarily for the convenience of the client or the provider;
8. Delivered in the least restrictive setting that will produce the desired results in accordance with the needs of the client.

Behavioral health conditions are the diagnoses listed in the current version of the Diagnostic and Statistic Manual as published by the American Psychiatric Association. (The NMAP does not reimburse for services for diagnoses of developmental disabilities, mental retardation, or V codes as part of this chapter.)

Behavioral health outcomes mean improving adaptive ability, preventing relapse or decompensation, stabilization in an emergency situation, or resolving symptoms.

20-001.16 Active Treatment: Active treatment is provided under an individualized treatment plan developed by the professional staff as required for each level of care. The plan must be based on a face-to-face comprehensive evaluation of the client's restorative needs and potentialities for a primary psychiatric diagnosis. An isolated service, such as a single session with the required professional or a routine laboratory test, not furnished under a planned program of therapy or diagnosis is not active treatment even though the service was therapeutic or diagnostic in nature.

The services must be reasonably expected to improve the client's condition or to determine a psychiatric diagnosis. The treatment must, at a minimum, be designed to reduce or control the client's psychiatric symptoms to facilitate the client's movement to a less restrictive environment within a reasonable period of time.

The kinds of services that meet this requirement include individual and group psychotherapy, family therapy, drug therapy, and adjunctive therapies, such as occupational therapy, recreational therapy, and speech therapy. These services must be face-to-face to meet the active treatment criteria. The adjunctive therapeutic services must be expected to improve the client's behavioral health condition. If the only activities prescribed for the client are primarily diversional in nature, (i.e., to provide some social, educational, or recreational outlet for the patient), NMAP does not consider the services as active treatment to improve the client's behavioral health condition.

The administration of a drug or drugs does not by itself necessarily constitute active treatment (i.e., the use of mild tranquilizers, sedatives, antidepressants, or antipsychotics solely to alleviate anxiety, insomnia, depression, or psychotic symptoms).

The active treatment services must be supervised, directed, and evaluated by a supervising practitioner. The supervising practitioner's participation in the services is an essential ingredient of active treatment. The services of other qualified professionals (i.e., occupational therapists, recreational therapists, speech therapists, etc.) must be prescribed by a supervising practitioner to meet the specific needs of the client. The supervising practitioner shall evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed on a regular basis through a face-to-face session, as defined for the level of care being provided. The evaluation must be based on periodic consultations and conferences with all current treatment staff, reviews of the client's clinical record, and regularly scheduled face-to-face client interviews as required for the level of care being provided.
20-001.17 Treatment Plans: A treatment plan must be established for each client. The treatment plan is a comprehensive plan of care formulated by the clinical staff under the direction of a supervising practitioner and is based on the individual needs of the client. The treatment plan validates the necessity and appropriateness of services and outlines the service delivery needed to meet the identified needs, reduce problem behaviors, and improve overall functioning.

The treatment plan must be based upon an assessment of the client's problems and needs in the areas of emotional, behavioral, and skills development. The treatment plan must be individualized to the client and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the client's progress; and the responsible professional.

The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

A treatment plan must be developed for every client within the time frames specified for each type of service and must be placed in the client's clinical record. If a treatment plan is not developed within the specified time frames, services rendered may not be Medicaid reimbursable.

The treatment plan must be reviewed and updated by the treatment team according to the client's level of functioning. Minimum time frames for treatment plan reviews are dependent on the type of service. Refer to each individual service description for the review requirements. The purpose of this review is to ensure that services and treatment goals continue to be appropriate to the client's current needs, and to assess the client's progress and continued need for psychiatric services. The supervising practitioner and treatment team members shall sign and date the treatment plan at each treatment plan review.

If the client is receiving services from more than one psychiatric provider, these agencies must coordinate their services and develop one overall treatment plan for the client or family. This treatment plan is used by all providers working with the client or family.
20-001.18 Transition and Discharge Planning: Whenever a client is transferred from one level of care to another, transition and discharge planning must be performed and documented by the treating providers, beginning at the time of admission.

Providers shall meet the following standards regarding transition and discharge planning:

1. Transition and discharge planning must begin on admission;
2. Discharge planning must be based on the treatment plan to achieve the client's discharge from the current treatment status and transition into a different level of care;
3. Transition and discharge planning must address the client's need for ongoing treatment to maintain treatment gains and to continue normal physical and mental development following discharge;
4. Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;
5. Treatment providers must make or facilitate referrals and applications to the next level of care or treatment provider;
6. The current provider shall arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into the next level of care; and
7. A written transition and discharge summary must be provided as part of the medical record.

20-001.19 Clinical Records: Clinical records must be arranged in a logical order such that the clinical information can be easily reviewed, audited, and copied. Each provider shall maintain accurate, complete, and timely records and shall always adhere to procedures that ensure the confidentiality of clinical data.

Treatment provided to the client must be written legibly or typed in the clinical record in a manner and with a frequency to provide a full picture of the therapies provided, as well as an assessment of the client's reaction to it. If three separate individuals cannot understand the information written in a record because of handwriting that is difficult to read, the program shall provide a readable format. Reimbursement for services may be denied if claims and/or medical records are not legible. Recoupment of previous payments for services may result if appropriate, legible, and complete records are not maintained for the client.

Providers of psychiatric services to individuals age 21 and older must comply with Department requests to review clinical records. This review may be of photocopies or on-site at the discretion of Department staff.
20-001.20 Inspections of Care: Under 42 CFR 456, Subpart I, the Department's inspection of care team shall periodically inspect the care and services provided to clients in any level of care under the following policies and procedures.

20-001.20A Inspection of Care Team: The inspection of care team must meet the following requirements:

1. The inspection of care team must have a psychiatrist who is knowledgeable about the level of care s/he is reviewing, plus other appropriate mental health and social service personnel;
2. The team must be supervised by a psychiatrist, but coordination of the team's activities remains the responsibility of the Division of Medicaid and Long-Term Care;
3. A member of the inspection of care team may not have a financial interest in any institution of the same type in which s/he is reviewing care but may have a financial interest in other facilities or institutions. A member of the inspection of care team may not review care in an institution where s/he is employed, but may review care in any other facility or institution.
4. A psychiatrist member of the team may not inspect the care of a client for whom s/he is the attending psychiatrist.
5. There must be a sufficient number of teams so located within the state that on-site inspections can be made at appropriate intervals for each facility or provider caring for clients.
6. A primary consumer, secondary consumer, or family member may be included in the inspection of care team at the discretion of the Department.

20-001.20B Frequency of Inspections: The inspection of care team shall determine, based on the quality of care and services being provided and the condition of clients, at what intervals inspections will be made. However, the inspection of care team shall inspect the care and services provided to each client at least annually, and/or more frequently as determined by the Inspection of Care team.

20-001.20C Notification Before Inspection: No facility or provider may be notified of the time of inspection more than 48 hours before the scheduled arrival of the inspection of care team. The Inspection of Care team may inspect a facility/provider with no prior notice, at their discretion.

20-001.20D Personal Contact With and Observation of Recipients and Review of Records: The team's inspection must include -

1. Personal contact with and observation of each client;
2. Review of each client's medical record; and
3. Review of the facility's or provider's policies as they pertain to direct patient care for each client being reviewed in the inspection of care, in accordance with 42 CFR 456.611(b)(1).
20-001.20E Determinations by the Team: The inspection of care team shall determine in its inspection whether -

1. The services available are adequate to -
   a. Meet the health needs of each client; and
   b. Promote his/her maximum physical, mental, and psychosocial functioning;
2. It is necessary and desirable for the client to remain in that level of care; and
3. It is feasible to meet the client's health needs through alternative institutional or noninstitutional services.

If, after an inspection of care is complete, the inspection of care team determines that a follow-up visit is required to ensure adequate care, a follow-up visit may be initiated by the team. This will be determined by the inspection of care team and will be noted in the inspection of care report.

20-001.20F Basis for Determinations: Under 42 CFR 456.610, in making the determinations by the team on the adequacy and appropriateness of services and other related matters, the team will determine what items will be considered in the review. This will include, but is not limited to, items such as whether -

1. The psychiatric and medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care, and when required, the plan of rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded;
2. The attending physician reviews prescribed medications at least every 30 days;
3. Test or observations of each client indicated by his/her medication regimen are made at appropriate times and properly recorded;
4. Psychiatrist, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the client;
5. The client receives adequate services, based on such observations as -
   a. Cleanliness;
   b. General physical condition and grooming;
   c. Mental status;
   d. Apparent maintenance of maximum physical, mental, and psychosocial function;
6. The client receives adequate rehabilitative services, as evidenced by -
   a. A planned program of activities to prevent regression; and
   b. Progress toward meeting objectives of the plan of care;
7. The client needs any services that are not furnished by the facility or through arrangements with others; and
8. The client needs continued placement in the facility or there is an appropriate plan to transfer the client to an alternate method of care, which is the least restrictive, most appropriate environment that will still meet the client's needs.
9. Involvement of families and/or legal guardians (see 471 NAC 20-001).
10. The facility's or provider's standards of care and policy and procedures meet the requirements for adequacy, appropriateness, and quality of services as they relate to individual Medicaid clients, as required by 42 CFR 456.611(b)(1).
20-001.20G Reports on Inspections: The inspection of care team shall submit a report to the Director of the Division of Medicaid and Long-Term Care on each inspection. The report must contain the observations, conclusions, and recommendations of the team concerning:

1. The adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, including physician services to clients; and
2. Specific findings about individual clients in the facility.

The report must include the dates of the inspection and the names and qualifications of the team members. The report must not contain the names of clients; codes must be used. The facility will receive a copy of the codes.

20-001.20H Copies of Reports: Under 42 CFR 456.612, the Department shall send a copy of each inspection report to:

1. The facility or provider inspected;
2. The facility's utilization review committee;
3. The Nebraska Department of Health and Human Services, Division of Public Health;
4. The Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care; and
5. Other licensing agencies or accrediting bodies at the discretion of the review team.

If abuse or neglect is suspected, Medicaid staff shall make a referral to the appropriate investigative body.

20-001.20J Facility or Provider Response: Within 15 days following the receipt of the inspection of care team's report, the facility shall respond to the review team's coordinator in writing, and shall include the following information in the response:

1. A reply to any inaccuracies in the report. Written documentation to substantiate the inaccuracies must be sent with the reply. The Department will take appropriate action to note this in a follow-up response to the facility;
2. A complete plan of correction for all identified Findings and Recommendations;
3. Changes in level of care or discharge;
4. Action to individual client recommendations; and
5. Projected dates of completion on each of the above;

If additional time is needed, the facility or provider may request an extension.
At the facility's or provider's request, copies of the facility's or provider's response will be sent to all parties who received a copy of the inspection report in 471 NAC 20-001.20H.

A return site visit may occur after the written response is received to determine if changes have completely addressed the review team's concerns from the IOC report.

The Department will take appropriate action based on confirmed documentation on inaccuracies.

20-001.20K Department Action on Reports: The Department will take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

20-001.20L Appeals: See 471 NAC 2-003 and 465 NAC 2-001.02 and 2-006.

20-001.20M Failure to Respond: If the facility or provider fails to submit a timely and/or appropriate response, the Department may take administrative sanctions (see 471 NAC 2-002) or may suspend Medicaid payment for an individual client or the entire payment to the facility or provider.

20-001.21 Procedure Codes: Providers shall use HCPCS/CPT procedure codes when submitting claims to the Department for Medicaid services. Procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

20-001.22 Initial Diagnostic Interview: For services in this chapter to be covered by Medicaid, the necessity of the service for the client shall be established through an Initial Diagnostic Interview. For services in this chapter to be covered by Medicaid, the client must have a diagnosable mental health disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistics Manual of the American Psychiatric Association that results in functional impairment which substantially interferes with or limits the person's role or functioning within the family, job, school, or community. This does not include V-codes or developmental disorders.
The Initial Diagnostic Interview is used to identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the client. This comprehensive plan of care will be outlined in the individualized treatment plan and should reflect an understanding of how the individual's particular issues will be addressed with the service. The Initial Diagnostic Interview must occur prior to the initiation of treatment interventions and must include a baseline of the client's current functioning and treatment needs. **EXCEPTION:** Clients receiving acute inpatient hospital services are not required to receive an Initial Diagnostic Interview before services are initiated. Providers of the acute services must facilitate or perform the Initial Diagnostic Interview.

The licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice must complete the Initial Diagnostic Interview within four weeks of the initial session with the therapist.
Initial Diagnostic Interview

1. Psychiatric Evaluation with relevant client information, mental status exam and diagnosis;
2. Recommendations:
   a. Treatment needs and recommended interventions for client and family;
   b. Identification of who needs to be involved in the client's treatment;
   c. Overall plan to meet the treatment needs of the client including transitioning to lower levels of care and discharge planning;
   d. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge;
   e. Recommended linkages with other community resources;
   f. Other areas that may need further evaluation.

Initial Diagnostic Interviews that are incomplete will not be reimbursable.

20-001.22A Involvement of the Supervising Practitioner: The supervising practitioner must meet face to face with the client to complete the Initial Diagnostic Interview. The supervising practitioner must work with the staff person to develop the recommendations. The supervising practitioner must sign the assessment document.
20-001.22B Payment for Initial Diagnostic Interview: Payment for the Initial Diagnostic Interview outlined in the previous section is made according to the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). Practitioners shall use the national code sets to bill for the Initial Diagnostic Interview. The reimbursement for these codes includes interview time, documentation review, and the writing of the report and recommendations.

Providers of the Initial Diagnostic Interview shall bill on claim form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The completed Initial Diagnostic Interview must be included in the client file and available for review upon request. Failure to produce documentation of an Initial Diagnostic Interview upon request, or lack of inclusion in the client file determined during review, shall be cause for claim denial and/or refund.

Medicaid will provide reimbursement for one Initial Diagnostic Interview per treatment episode. Addendums may be included if additional information becomes available. If the client remains involved continuously in treatment for more than one year, reimbursement for an Initial Diagnostic Interview may be available annually. If the client leaves treatment prior to a successful discharge and returns for further treatment, the provider must assess the need for an addendum or a new Initial Diagnostic Interview. A second Initial Diagnostic Interview within a year must be prior authorized. Practitioners shall use national code sets to bill for this activity.

For further instructions on billing for outpatient mental health and substance abuse services, please see 471 NAC 20-002.12.

20-001.22C Procedure Codes and Descriptions for Initial Diagnostic Interviews: HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

20-001.22D Distribution of the Initial Diagnostic Interview: Providers must distribute complete copies of the Initial Diagnostic Interview to other treatment providers in a timely manner when the information is necessary for a referral and the appropriate releases of information are secured.
20-002 Outpatient Psychiatric Services: Note: All requirements in 471 NAC 20-001 apply to outpatient psychiatric services.

20-002.01 Covered Outpatient Psychiatric Therapeutic Services: Nebraska Medical Assistance Program covers the following outpatient psychiatric therapeutic services for clients age 21 and older as defined in 471 NAC 20-001.12:

1. Psychiatric evaluation;
2. Psychological evaluation;
3. Psychological testing;
4. Individual Psychotherapy;
5. Group Psychotherapy (a group overview must be approved by Medicaid prior to billing for this service);
6. Family Psychotherapy Services;
7. Family Assessment;
8. Medication checks by a physician or a physician extender;

Treatment for chemical dependency is not covered for clients age 21 and older.

Skilled nursing services for the monitoring of medications is available through Home Health Agencies (see 471 NAC 9-000).

20-002.02 Psychiatric Therapeutic Staff Standards: The following psychiatric therapeutic staff may provide services and must meet the requirements as defined in 471 NAC 20-001.13:

1. Physician;
2. Licensed Psychologist;
3. Physician extenders;
4. Licensed Independent Mental Health Practitioner;
5. Allied Health Therapists.

20-002.02A Location of Services: Outpatient psychiatric services by qualified staff may be provided in:

1. A licensed community mental health program which meets the criteria for approval by the Joint Commission on Accreditation of Healthcare Organizations, CARF, COA, or AOA;
2. A licensed and certified hospital which provides psychiatric services and which:
   a. Is maintained for the care and treatment of patients with primary psychiatric disorders;
b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard setting in that state;

c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or AOA;

d. Has licensed and certified psychiatric beds;

e. Meets the requirements for participation in Medicare for psychiatric hospitals; and

f. Has in effect a utilization review plan applicable to all Medicaid clients;

3. A licensed and certified hospital which provides acute medical services and which -

a. Is maintained for the care and treatment of patients with acute medical disorders;

b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard setting in that state;

c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or AOA;

d. Meets the requirements for participation in Medicare for acute medical hospitals; and

e. Has in effect a utilization review plan applicable to all Medicaid clients;

4. A physician's private office;

5. A licensed psychologist's private office;

6. An allied health therapist's private office;

7. The client's home;

8. Nursing homes; or

9. Rural Mental Health Clinics or Federally Qualified Health Centers.

Therapy is not reimbursable in any other location.

20-002.03 Provider Agreement: A provider of psychiatric outpatient services shall complete a provider agreement, and submit the form to the Department for approval:

1. Independent psychiatric service providers (physicians, licensed psychologists) shall complete Form MC-19, "Medical Assistance Provider Agreement." The provider agreement issued to the supervising practitioner (or clinic) is used to claim services provided by allied health therapists who are in his/her employ or supervision. For outpatient psychiatric services provided through a group practice, the Provider Agreement must be kept current by providing the Department with:

   a. The termination date of any therapist leaving the group practice;

   b. The initial employment date of any therapist joining the group practice;

   c. A current resume detailing education and clinical experience for each application for allied health therapists.
2. Hospitals as defined in 471 NAC 20-002.02A providing outpatient psychiatric services shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement."

Providers are responsible for verifying that allied health therapists, physicians, physician extenders, and licensed psychologists are appropriately licensed for the correct scope of practice.

20-002.03A Geographically-Deprived Areas: A geographically-deprived area is an area where a psychiatrist is not available in the community, or within a reasonable driving distance of the community, to provide services. A physician who is qualified, skilled, and experienced in the diagnosis and treatment of psychiatric disorders may serve as an alternative to a psychiatrist for outpatient services in a geographically-deprived area. A resume detailing the physician's mental health education and experience must accompany the provider agreement. When outpatient psychiatric services are provided under these conditions, the physician is subject to all policy requirements outlined for psychiatrists. Psychiatric services provided by the attending physician, other than a psychiatrist, are limited to the following:

Psychotherapy services provided in a physician's office which do not exceed six months without documented consultation between the physician providing the service and a psychiatrist.

20-002.04 Coverage Criteria for Outpatient Psychiatric Services: The Nebraska Medical Assistance Program covers outpatient psychiatric therapeutic services listed in 471 NAC 20-002.01 when the services are medically necessary and provide active treatment as defined in 471 NAC 20-001.15 and 20-001.16.

Medical necessity and active treatment for outpatient services is documented through the use of the Department's approved treatment planning document (471 NAC 20-002.06) which must be developed by a licensed practitioner and supervising practitioner based on a thorough evaluation of the client's restorative needs and potentialities for a primary psychiatric diagnosis.
20-002.04A Services Provided by Allied Health Therapists: Services provided by Allied Health Therapists (as defined in 471 NAC 20-001.13) must be prescribed and provided under the direction of a supervising practitioner. Supervision must meet the active treatment criteria in 471 NAC 20-001.16.

Definition and Practice of Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action. This includes, but is not limited to, review of treatment plan and progress notes, client specific case discussion, periodic assessments of the client (annually, or more often if necessary), and diagnosis, treatment intervention or issue specific discussion. The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment. The critical involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview, the treatment plan, and the interventions provided.

The supervising practitioner (or their designated and qualified substitute) must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.

Supervisory contact may occur in a group setting.

Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.

Psychiatric resident physicians and physician extenders may not supervise allied health therapists for Medicaid services.

The supervising practitioner shall periodically evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed.

The supervising practitioner must personally re-evaluate the client through a face-to-face contact annually or more often, if necessary.
20-002.05 Initial Diagnostic Interview: Before a client is accepted for treatment, an Initial Diagnostic Interview must be completed.

The supervising practitioner must evaluate the client within four weeks of the initial contact with the therapist, or sooner if necessary. If the client does not continue with therapy sessions past the fourth session or does not attend the assessment session with the supervising practitioner, the therapist must review the specific case with the supervising practitioner, to establish a diagnosis and confirm that the interventions were appropriate. For clients continuing in therapy, reimbursement will not be available for more than four sessions until the client is assessed by the supervising practitioner.

20-002.06 Treatment Planning: When treatment is initiated, the provider shall work with the client and family (at the client's discretion) to develop the treatment plan. If the client is accepted for treatment, the treatment plan must be completed within two sessions of the assessment by the supervising practitioner and is based on the following:

1. The client must have sufficient need for active psychiatric treatment at the time the psychiatric service provider accepts the client; and
2. The treatment must be the best choice for expecting reasonable improvement in the client's psychiatric condition.

The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.
20-002.06A  Treatment Planning Document Update: The treatment plan must be reviewed and updated every 90 days, or more frequently if indicated. The client's clinical record must include the supervising practitioner's comments on the client's response to treatment and changes in the treatment plan. The supervising practitioner must review and sign off on the updated treatment plan prior to its initiation. Changes in the treatment plan must be noted on the current treatment planning document. In addition, the psychiatric service provider shall complete an updated treatment planning document annually, or more frequently if necessary, to reflect changes in treatment needs. A copy of the current treatment planning document must be maintained in the client's medical record.

For services provided under the supervision of a supervising practitioner, the signature of the supervising practitioner on the treatment planning document indicates his/her agreement that the scheduled treatment interventions are appropriate.

20-002.07 Documentation in Client's Clinical Records: All documents submitted to Medicaid must contain sufficient information for identification (i.e., client's name, dates, and time of service, provider's name). Documentation must be legible. The client's medical record must also include -

1. The Initial Diagnostic Interview;
2. The treatment plan, (including the initial document, updates, and current);
3. The client's diagnosis. A provisional or interim psychiatric diagnosis must be established by the supervising practitioner at the time the client is accepted for treatment. This diagnosis must be reviewed and revised as a part of the treatment plan;
4. A chronological record of all psychiatric services provided to the client, the date performed, the duration of the session, and the staff member who conducted the session;
5. A chronological account of all medications prescribed, the name, dosage, and frequency to be administered and client's response;
6. A comprehensive family assessment.
7. A clear record of family and community involvement;
8. Documentation verifying coordination with other therapists when more than one provider is involved with the client/family; and

20-002.08 Transition/Discharge Planning Services: Providers of outpatient psychiatric services shall meet the transition/discharge planning requirements noted in 471 NAC 20-001.18.
20-002.09 Utilization Review: Payment for outpatient psychiatric services is based on adequate legible documentation of medical necessity and active treatment. All outpatient claims are subject to utilization review before payment. Illegible documentation may result in denial of payment (see 471 NAC 20-001.19).

Additional documentation from the client's clinical record may be requested prior to considering authorization of payment when the treatment plan does not adequately document medical necessity or active treatment.

20-002.10 Guidelines for Specific Services

20-002.10A Psychological Testing and Evaluation Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Medical necessity must be documented.

Testing and evaluation services may be performed by a licensed psychologist, or by a specially licensed psychologist or a master's level person approved to administer psychological testing under the supervision of a licensed psychologist.

If testing and evaluation services are provided by a licensed, non-certified psychologist, the services must be ordered by a supervising practitioner. The treatment plan must be signed by the supervising practitioner.

A copy of the testing narrative summary must be kept in the client's clinical record. If the evaluation is court ordered, the provider shall note this on the treatment plan and include documentation of medical need for the service. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

20-002.10B Grandparented Masters Psychologists: Services provided by master's level clinical psychologists whose certification has been grandparented by the Department of Health and Human Services, Division of Public Health may be covered under 471 NAC 20-002. Documentation of the grandparented status may be required.

20-002.10C Medication Checks: Medication checks may only be done when medically necessary. When a physician provides psychotherapy services, medication checks are considered a part of the psychotherapy service.

The supervising physician may provide a medication check when a licensed psychologist or an allied health therapist provides the psychotherapy service. Only physicians and psychiatrically trained physician extenders may provide medication checks.
**20-002.10D  After-Care**: After-care as defined by the American Psychiatric Association is a complex system of services including, but not limited to, psychotherapy, medication checks, and social, rehabilitative, and educational services required and necessary to deinstitutionalize the chronic patient who has undergone extended hospital treatment and care. This "service package" does not meet the criteria of active treatment and is not covered by the Nebraska Medical Assistance Program. Individually-identified services may be claimed under the appropriate HCPCS/CPT procedure code and are subject to the active treatment standard.

**20-002.10E  Professional and Technical Components for Hospital Diagnostic and Therapeutic Services**: For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, refer to 471 NAC 10-003.05C, 10-003.05D, 10-003.05E, and 10-003.05F.

**20-002.10F  Travel to the Home of Individuals Who Have Handicaps**: If a client has a handicapping physical condition that prevents them from traveling to a mental health clinic or office, the provider may request prior authorization to bill for mileage to the client's home. The following requirements must be met:

1. The provider requests prior authorization before the initiation of services;
2. The treatment must meet the criteria for active treatment and medical necessity;
3. The client's handicapping physical condition prevents their travel to the mental health clinic or office; and
4. The client's home is more than 30 miles from the clinic or office.

This information must be provided, in writing, to the Medicaid Central Office staff or their designee for consideration.

**20-002.10G  Family Assessment**: NMAP covers family assessments used to identify the functional level of the family unit and the system changes that would influence this functional level. This includes interviews with the client and collateral parties.
20-002.11 Payment for Outpatient Psychiatric Services

20-002.11A Payment for Outpatient Psychiatric Services in a Hospital: Payment for outpatient psychiatric services is made according to Nebraska Medicaid Practitioner Fee Schedule. The Nebraska Medical Assistance Program (NMAP) pays for covered outpatient mental health services, except for laboratory services, at the lower of:

1. The provider’s submitted charge; or
2. The allowable amount for that procedure code in the Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The maximum allowable dollar amount; or
   c. The reasonable charge for the procedure as determined by the Division of Medicaid and Long-Term Care (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

20-002.11B Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Division of Medicaid and Long-Term Care determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.
20-002.12 Billing Requirements: For outpatient psychiatric service providers, the following requirements must be met.

1. Community mental health programs providing outpatient psychiatric services shall submit all claims for outpatient services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

   Payment for approved outpatient psychiatric services provided by employees of a community mental health program is made to the facility.

2. Hospitals providing outpatient psychiatric services shall submit all claims for non-physician services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

   All M.D. services shall be submitted on an appropriately completed CMS-1500.

   Payment for approved outpatient psychiatric services provided by employees of a hospital is made to the facility.

3. Independent providers of outpatient psychiatric services (psychiatrist or clinical psychologist in a private office who is not an employee of a hospital or community mental health center) shall submit all claims for outpatient psychiatric services provided in their private office on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

   Payment for approved outpatient psychiatric services provided in an independent provider's private office is made to the provider as identified on the provider agreement.
20-002.12A Documentation for Claims: For outpatient psychiatric services, unless otherwise instructed by Medicaid or their designee, the following documentation must be kept in the client’s file for each claim:

1. The initial treatment plan; or
2. An updated version of the treatment plan completed every 90 days.

For psychological testing and evaluation services, unless otherwise instructed by Medicaid, the following information must be kept in the client’s file:

1. The treatment plan;
2. Medical necessity for the service documented on the treatment plan;
3. The documentation that the evaluation services will reasonably be expected to contribute to the diagnosis and plan of care established for the individual client; and
4. A narrative of the testing results.

20-002.13 Procedure Codes and Descriptions: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).
20-003  Adult Day Treatment Psychiatric Services: Psychiatric day treatment is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric client to a status in which the client is capable of functioning within the community with less frequent contact with the psychiatric health care provider.

Day treatment services must meet all requirements in 471 NAC 20-001.

20-003.01  Covered Day Treatment Services: Psychiatric day treatment programs shall provide the following mandatory services and at least two of the following optional services. Payment for both mandatory services and optional services is included in the rate for day treatment. Providers shall not make any additional charges to the Department or to the client.

20-003.01A  Mandatory Services: The following services must be included in a program for psychiatric day treatment to be approved for participation in the Nebraska Medical Assistance Program. See 471 NAC 20-001 for definitions.

1. Medically Necessary Psychotherapy Services: These services must demonstrate active treatment of a patient with a psychiatric condition. These services are subject to program limitations and must be provided by professionals operating within the appropriate scope of practice.
   a. Individual Psychotherapy;
   b. Group Psychotherapy;
   c. Family Psychotherapy;
   d. Family Assessment if appropriate;

2. Medically Necessary Nursing Services: Services directed by a Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the care and treatment that is indicated by the Department approved treatment planning document approved by the supervising practitioner.

3. Medically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a Licensed Psychologist. If testing and evaluation services are provided by a specially licensed psychologist or approved Master's level person, the services must be ordered by a supervising practitioner. Medical necessity must be documented by the supervising practitioner. Reimbursement for psychological Diagnostic Services is included in the per diem and will not be reimbursed for separately.
4. **Medically Necessary Pharmaceutical Services**: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, or licensed practical nurse.

5. **Medically Necessary Dietary Services**: If meals are provided by a day treatment program, services must be supervised by a registered dietitian, based on the client's individualized medical diet needs. The program may contract for these services through an outside licensed certified facility.

6. Transition and discharge planning must meet the requirements of 471 NAC 20-001.18.

**20-003.01B Optional Services**: The program must provide two of the following optional services. The client must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy. In appropriate circumstances, occupational therapy may be covered if prescribed as an activities therapy in a psychiatric program:

1. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
   a. Recreational Therapy;
   b. Speech Therapy;
   c. Occupational Therapy;
   d. Vocational Skills Therapy;
   e. Self-Care Services: Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.

2. **Social Work provided by a bachelor's level social worker**: Social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment, i.e., case management type services.

3. Social Skills Building;

4. Life Survival Skills.
20-003.01C Special Treatment Procedures in Day Treatment: If a client needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in day treatment are limited to physical restraint, and locked time out (LTO). Mechanical restraints and pressure point tactics are not allowed.

Facilities must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a client's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The client's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO or physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

20-003.02 Standards for Participation

20-003.02A Provider Standards: Providers of day treatment services shall meet the following standards:

1. Non-Hospital Based Day Treatment: A center providing day treatment must be -
   a. Appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; and
   b. Accredited by JCAHO, CARF, COA, or AOA.
2. Hospital Based Day Treatment: A hospital providing on-site day treatment must -
   a. Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
   b. Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or AOA;
   c. Meet the requirements for participation in Medicare; and
   d. Have in effect a utilization review plan applicable to all Medicaid clients.

When hospitals provide services in freestanding facilities, the freestanding facility must be appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health.
20-003.02B Service Standards:

1. The program must provide a minimum of three hours of services five days a week, which is considered a half day for billing purposes. A minimum of six hours a day is considered a full day of service. Services may not be prorated for under three (or six) hours of services;

2. A designated supervising practitioner must be responsible for the psychiatric care in a day treatment program. The supervising practitioner must be present on a regularly-scheduled basis and must assume clinical responsibility for all patients. If the supervising practitioner is present on a part-time basis, one of the following shall assume delegated professional responsibility for the program and must be present at all times when the program is providing services:
   a. A licensed physician;
   b. A licensed psychologist;
   c. Licensed Independent Mental Health Practitioner; or
   d. An allied health therapist;

3. Any supervising practitioner may refer a client to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner;

4. All treatment must be conducted under the supervision of the supervising practitioner in charge of the program;

5. Psychotherapy Staff: See 471 NAC 20-001 for definitions.
   a. Physician;
   b. Licensed Psychologist;
   c. Licensed Independent Mental Health Practitioner; and
   d. Allied health therapists. All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under his/her supervision. The supervising practitioner's personal involvement in all aspects of the client's psychiatric care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes).

6. Admission Criteria: The following criteria must be met for a client's admission to a psychiatric day treatment program:
   a. The client must have sufficient medical need for active psychiatric treatment at the time of admission to justify the expenditure of the client's and program's time, energy, and resources; and
   b. Of all reasonable options for active psychiatric treatment available to the client, treatment in this program must be the best choice for expecting a reasonable improvement in the client's psychiatric condition.
7. **Pre-Admission Evaluation:** Before the client is admitted to the program, the supervising practitioner shall complete an Initial Diagnostic Interview to validate the appropriateness of care. When a client is transferred from inpatient hospital care to day treatment, the inpatient evaluation and discharge summary documenting the rationale of transfer as part of the treatment plan serves the same purpose as the Initial Diagnostic Interview. The evaluation must be filed in the client's medical record. The pre-admission evaluation must include:
   a. A clinical assessment of the health status and related psychological, medical, social, and educational needs of the client; and
   b. A determination of the range and kind of services required.

The supervising practitioner shall personally complete an Initial Diagnostic Interview which must be used to develop the plan of care if all admission criteria have been met;

8. **Treatment Plan:** The program supervising practitioner shall determine the psychiatric diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.

The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

The treatment plan shall be completed upon the client's admission to the program;

9. At least every 30 days thereafter, a treatment plan review must be conducted by the multi-disciplinary team, including the supervising practitioner. The treatment plan reviews must be documented. The treatment plan must be signed by the program supervising practitioner for day treatment services;

10. The supervising practitioner must personally evaluate the client every 30 days, or more often, as medically necessary. This evaluation must occur in a one-to-one, face-to-face session separate from the treatment plan review;
11. Every 30 days a utilization review must be conducted per 471 NAC 20-003.07. This review must be documented on the treatment plan. Utilization review is not required for the calendar month in which the client was admitted;

12. The program must have a description of each of the services and treatment modalities available. This includes psychotherapy services, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other psychiatric day treatment services.
   a. The program must have a description of how the family-centered requirement in 471 NAC 20-001 will be met, including a complete description of any family assessment and family psychotherapy services.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends;

b. The program must have a description of how the community-based requirement in 471 NAC 20-001 will be met;

c. The program shall state the qualifications, education, and experience of each staff member and the therapy services each provides;

d. The program must have a daily schedule covering the total number of hours the program operates per day. The schedule must be submitted to the Department for approval. The program must be fully staffed and supervised during the time the program is available for services, and must provide at least three hours of approved treatment for each day services are provided. This schedule must be updated annually, or more frequently if appropriate;
13. Outpatient Observation: When appropriate for brief crisis stabilization, outpatient observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used as follows:
An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone). If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed and whether s/he remained in the hospital past midnight or the census-taking hour, and all inpatient medical review prior-authorization requirements apply;

14. The program must have a written plan for immediate admission or readmission for appropriate inpatient psychiatric services, if necessary. The written plan must include a cooperative agreement with a psychiatric hospital or distinct part of a hospital, as outlined in 471 NAC 20-007. A copy of this agreement must accompany the provider application and agreement.

20-003.03 Provider Agreement: A provider of psychiatric day treatment services shall complete a provider agreement and submit the form to the Department for approval. The provider shall attach to the provider application and agreement a written overview of the program including philosophy, objectives, policies and procedures, confirmation that the requirements in 471 NAC 20-001 and 471 NAC 20-002 are met and any other information requested by Medicaid staff. Staff must meet the standards outlined in 471 NAC 20-001.13; and:

1. Community mental health programs and licensed mental health clinics shall complete Form MC-19, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document (FA-20) must also be submitted. The provider application and agreement must be renewed annually to coincide with the submittal of the cost report. Satellites of community mental health programs shall bill the Department through their main community mental health program, unless the satellite has a separate provider number under Medicare. A satellite of a community mental health program that has a separate provider number under Medicare shall complete a separate provider agreement. All claims submitted to the Department by these satellites must be filed under the satellite's Medicaid provider number. The facility must have in effect a utilization review plan applicable to all Medicaid clients.

2. Hospitals shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document (FA-20) must also be submitted.

20-003.03A Annual Update: The program shall update the provider agreement, program overview, and cost report annually and whenever requested by the Division of Medicaid and Long-Term Care.
20-003.04 Coverage Criteria for Day Treatment Psychiatric Services: The Nebraska Medical Assistance Program covers psychiatric day treatment services for clients 21 and over when the services meet the requirements in 471 NAC 20-001.

The client must be observed and interviewed by the program supervising practitioner at least every 30 days or more frequently if medically necessary and the interaction must be documented in the client's medical record.

20-003.04A Services Not Covered Under Medicaid: Payment is not available for psychiatric day treatment services for clients -

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-002, Services Provided Outside Nebraska;
2. Living in long term care facilities or Institutes for Mental Disease;
3. Whose needs are social or educational and may be met through a less structured program;
4. Whose primary diagnosis and functional impairment is psychiatric in nature but is not stable enough to allow them to participate in and benefit from the program; or
5. Whose behavior may be very disruptive and/or harmful to other program participants or staff members.

20-003.05 Documentation in the Client's Clinical Record: All documents submitted to Medicaid must contain sufficient information for identification (i.e., client's name, dates of service, provider's name) and must be legible. Each client's clinical record must contain the following documentation:

1. The supervising practitioner's orders;
2. The Initial Diagnostic Interview and referral documented by the supervising practitioner;
3. The treatment plan;
4. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the team's progress notes must be recorded at least weekly. The progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan, as indicated by the client's condition, and discharge planning;
5. Documentation indicating compliance with all requirements in 471 NAC 20-001;
6. The program's utilization review committee’s abstract or summary; and
7. The discharge summary.

20-003.06 Transition and Discharge Planning: Each provider must meet the 471 NAC 20-001 requirements for transition and discharge planning.
REV. SEPTEMBER 28, 2008   NEBRASKA DEPARTMENT OF   NMAP SERVICES
MANUAL LETTER # 79-2008   HEALTH AND HUMAN SERVICES   471 NAC 20-003.07

20-003.07 Utilization Review (UR): Each program is responsible for establishing a utilization
review plan and procedure which meets the following guidelines. A site visit by Medicaid staff
for purposes of utilization review may be required for further clarification.

20-003.07A Components of UR: Utilization review must provide -

1. Timely review (at least every 30 days) of the medical necessity of admissions
   and continued treatment;
2. Utilization of professional services provided;
3. High quality patient care; and
4. Effective and efficient utilization of available health facilities and services.

20-003.07B UR Overview: An overview of the program's utilization review process must
be submitted with the provider application and agreement before the program is enrolled
as a Medicaid provider. The overview must include -

1. The organization and composition of the utilization review committee which is
   responsible for the utilization review function;
2. The frequency of meetings (not less than once a month);
3. The type of records to be kept; and
4. The arrangement for committee reports and their dissemination, including how
   the supervising practitioner is informed of the findings.

20-003.07C UR Committee: The utilization review committee must consist of a
supervising practitioner and at least two mental health practitioners (as defined in 471
NAC 20-001). A licensed psychologist may replace one of the allied health staff
members. The committee's reviews may not be conducted by any person whose primary
interest in or responsibility to the program is financial or who is professionally involved in
the care of the client whose case is being reviewed. At the Department's discretion, an
alternative plan for facilities that do not have these resources readily available may be
approved.

20-003.07D Basis of Review: The review must be based on -

1. The identification of the individual client by appropriate means to ensure
   confidentiality;
2. The identification of the supervising practitioner;
3. The date of admission;
4. The diagnosis and symptoms;
5. The supervising practitioner plan of treatment; and
6. Other supporting materials (progress notes, test findings, consultations) the
   group may deem appropriate.
20-003.07E Contents of Report: The written report must contain -

1. An evaluation of treatment, progress, and prognosis based on -
   a. Appropriateness of the current level of care and treatment;
   b. Alternate levels of care and treatment available; and
   c. The effective and efficient utilization of services provided;
2. Verification that -
   a. Treatment provided is documented in the client's record;
   b. All entries in the client's record are signed by the person responsible for entry. The supervising practitioner shall sign all orders; and
   c. All entries in the client's record are dated;
3. Recommendations for -
   a. Continued treatment;
   b. Alternate treatment/level of care; and
   c. Disapproval of continued treatment.
4. The date of the review;
5. The names of the program utilization review committee members; and
6. The date of the next review if continued treatment is recommended.

A copy of the admission review and the extended stay review must be attached to all claims for psychiatric services submitted to the Department for payment.

20-003.08 Payment for Psychiatric Day Treatment Services: Payment for psychiatric day treatment services will be based upon rate setting by the Department. Payment rates for psychiatric day treatment services for individuals age 21 and older will be on a unit basis. Rates are set annually, for the period July 1 through June 30. Rates are set prospectively for this period, and are not adjusted during the rate period.

Providers are required to report their costs on an annual basis. Providers may choose any fiscal year end that they desire. Providers desiring to enter the program who have not previously reported their costs, or that are newly operated, are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers shall submit cost and statistical data on Form FA-20. The provider shall submit one original Form FA-20 to the Department within 90 days of the close of fiscal year, or change in ownership or management. One 15-day extension may be granted under extenuating circumstances if requested, in writing, prior to the date. Providers shall compile data based on generally accepted accounting principles and the accrual method of accounting based on the provider's fiscal year. 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. If the 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 no further payment will be made until a proper cost report is filed.
In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care requirements and discharge planning.

The Department does not guarantee that all costs will be reimbursed. The Form FA-20 cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

20-003.08A Payment Rates for Psychiatric Day Treatment Services Provided by State-Operated Facilities: Psychiatric day treatment centers operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

20-003.08B Unallowable Costs: The following costs are not allowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expense, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of the day treatment program. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-related facilities and operations included in expense;
8. Insurance and/or annuity premiums on the life of officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Cost 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. Education costs;
12. 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;
13. Return on equity;
14. Costs for services which occurred in a prior or subsequent fiscal year are unallowable;
15. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service;
16. Costs of amusements, social activities, and related expenses for employees and governing body members are unallowable, except when part of an authorized client treatment program;
17. Costs of alcoholic beverages are unallowable;
18. Costs resulting from violations of, or failure to comply with federal, state, and local laws and regulations are unallowable;
19. Costs relating to lobbying or attempts to influence/promote legislative action by local, state, or federal government are unallowable; and
20. Costs of lawsuits or other legal or court proceedings against the Department, or its employees, or State of Nebraska are unallowable.

20-003.08C Suspension or Termination of License: The Department does not make payment for care provided after 30 days following the date of expiration or termination of the provider's license or certificate to operate under Title XIX. 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 Title XIX.

20-003.08D Appeal Process: Final administrative decision or inaction in the rate setting process is subject to administrative appeal. The provider may request an appeal, in writing, from the Director for a hearing within 90 days of the decision or inaction. Regulations for appeals and fair hearings are contained in 465 NAC 2-001.02 and 2-006 ff.

20-003.08E Administrative Finality: An administrative decision or inaction in the allowable cost determination process, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" is an action taken by the Director to re-examine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority for deciding whether to reopen an administrative decision or inaction. The action may be taken:

1. On the initiative of the Department within the three-year period;
2. In response to a written request of 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 any law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider has no right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.
20-003.09  Record Retention: The provider shall 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. The Department shall retain all cost reports for at least five years after receipt from the provider.

20-003.10  Billing Requirements: For day treatment services, the following requirements must be met:

1. Providers of non-hospital based day treatment services shall submit claims for day treatment services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

   Payment for approved day treatment services is made to the facility.

2. Providers of hospital based day treatment services shall submit claims for services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

   Payment for approved hospital based day treatment services is made to the hospital.

20-003.10A  Documentation for Claims: The following documentation, kept in the client’s file, is required for all claims for day treatment services:

   1. Initial Diagnostic Interview;
   2. Supervising practitioner orders;
   3. Nurses’ notes; and
   4. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment. Reimbursement may be denied if claims and/or documentation are illegible (see 471 NAC 20-001.19).

20-003.10B  Exception: Additional documentation from the client's medical record may be requested by the Department prior to considering authorization of payment. Progress notes for other Medicaid clients may be requested when the treatment report does not adequately explain family psychotherapy or medical necessity cannot be determined.

20-003.11  Procedure Codes and Descriptions for Psychiatric Day Treatment: HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).
20-003.12 Costs Not Included in the Day Treatment Fee: The mandatory and optional services are considered to be part of the fee for day treatment services. The following charges can be reimbursed separately from the day treatment fee when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

20-004, 20-005 (Reserved)
20-006  Adult Subacute Inpatient Hospital Psychiatric Services: Subacute inpatient hospital psychiatric services for clients 21 and over are medically necessary short-term psychiatric services provided to a client. The care and treatment of a subacute inpatient with a primary psychiatric diagnosis must be under the direction of a Nebraska licensed psychiatrist who meets the state's licensing criteria and is enrolled as a Medicaid provider with the Department. Subacute inpatient hospital psychiatric services must be prior-authorized by the Department-contracted peer review organization or management designee. In addition, out-of-state subacute hospitalizations must be approved by the Department.

20-006.01  Provider Agreement: A hospital that provides subacute inpatient psychiatric services must complete Form MC-20, "Medical Assistance Hospital Provider Agreement," (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a Medicaid provider of subacute inpatient hospital psychiatric services. The hospital must submit with the provider agreement:

1. A complete description of the psychiatric program and the elements of the program (i.e., policies and procedures, staffing, services, etc.);
2. A statement of the total number of licensed inpatient psychiatric beds, designated as subacute psychiatric beds that are approved by the Nebraska Department of Health and Human Services, Division of Public Health or agency in the state in which the facility is located; a listing of the bed numbers for those licensed psychiatric beds; and the size of the proposed subacute inpatient psychiatric unit;
3. Documentation that the subacute inpatient program meets the family-centered, community-based requirements in 471 NAC 20-001;
4. A description of how individual, group, and family psychotherapy services as well as other psycho-educational and rehabilitation services will be provided;
5. A description of how the subacute inpatient hospital psychiatric services will interface with community services for discharge planning and service provision after discharge;
6. A copy of the most recent Joint Commission Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA) accreditation survey; and
7. Any other information requested.

Any facility requesting a provider agreement must make the facility available for an on-site review before issuance of a provider agreement.
Standards for Participation for Subacute Inpatient Hospital Psychiatric Service Providers: A hospital that provides subacute inpatient hospital psychiatric services must meet the following standards for participation to ensure that payment is made only for subacute inpatient psychiatric treatment. The hospital or unit of an acute care hospital:

1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the American Osteopathic Association (AOA);
4. Meets the requirements for participation in Medicare for psychiatric hospitals;
5. Has in effect a utilization review plan applicable to all Medicaid clients;
6. Must have medical records that are sufficient to permit the Department to determine the degree and intensity of treatment furnished to the client;
7. Must meet staffing requirements the Department finds necessary to carry out an active treatment program (see 471 NAC 20-006.03);
8. Must encourage the client and family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws;
9. Must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family/guardian/caretaker schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings; and
10. Must document their attempts to involve the client and the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered to involve family. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.
 Staffing Standards for Participation: Subacute inpatient psychiatric hospital must have staff adequate in number and qualified to carry out a subacute psychiatric program for treatment for individuals who are in need of further psychiatric stabilization, treatment, rehabilitation, and recovery activities. The hospital must meet the following standards.

1. Hospital Personnel: Hospitals that provide subacute inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required to carry out an intensive and comprehensive treatment program that includes evaluation of individual and family needs; establishment of individual and family treatment goals; and implementation, directly or by arrangement, of a broad-range psychiatric treatment program including, at least, professional psychiatric, medical, nursing, social services, psychological, psychotherapy, psychiatric rehabilitation, and recovery therapies required to carry out an individual treatment plan for each patient and their family. The following standards must be met:

   a. Qualified professional psychiatric staff must be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include:
      (1) Initial Diagnostic Interview;
      (2) Nursing assessment by a licensed registered nurse;
      (3) Substance abuse assessment as appropriate;
      (4) Laboratory, radiological, and other diagnostic tests as necessary; and
      (5) A physical examination including a complete neurological examination when indicated within 24 hours after admission by a licensed physician.

   b. The number of qualified professional personnel and paraprofessionals, including licensed professional staff and technical and supporting personnel, must be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals; and to plan, carry out, and periodically revise a treatment plan for each client.
      (1) Qualified staff must be available to provide treatment intervention, social interaction and experiences, education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance abuse education, appropriate nursing interventions and structured milieu therapy. Available services must include individual, group, and family therapy, group living experiences, occupational and recreational therapy and other prescribed activities to maintain or increase the individual’s capacity to manage his/her psychiatric condition and activities of daily living. A minimum of 42 structured, scheduled, and documented treatment hours are required per week.
      (2) The program must provide environmental and physical limitations required to protect the client's health and safety with a plan to develop the client's potential for return to his/her home, supervised adult living, or skilled nursing facility. The treatment milieu must be a safe, organized, structured environment at the least restrictive level of care to meet the individualized treatment needs of the client.
2. **Medical Director of Subacute Inpatient Psychiatric Services**: Subacute inpatient psychiatric services must be under the supervision of a psychiatrist (supervising practitioner) who is identified as medical director and is qualified to provide the clinical direction and the leadership required for an intensive psychiatric subacute inpatient treatment program. The number and qualifications of additional psychiatrists must be adequate to provide essential psychiatric services. The medical director may also serve as the attending psychiatrist for each client depending on the size of the program. The following standards must be met:
   a. The medical director and any attending psychiatrist/s must meet the training and experience requirements for a psychiatrist licensed to practice in the state where services are provided;
   b. The program must identify a covering or alternative psychiatrist when the medical director is not available to provide direction and supervision of the direct care of the client and the treatment program;
   c. The psychiatrist's personal involvement in all aspects of the client's psychiatric care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes);
   d. The medical director/attending psychiatrist must be available, in person or by telephone, to provide assistance and direction to the treatment team as needed.

3. **Availability of Physicians and Other Medical Consultation**: Physicians and other appropriate professional consultants such as medical, psychopharmacological, dental, and emergency medical services must be available to provide medical, surgical, diagnostic, and treatment services, including specialized services. If medical, surgical, diagnostic, and treatment services are not available within the hospital, qualified physician consultants or attending physicians must be immediately available, or a satisfactory arrangement must be established for transferring patients to a general hospital certified for Medicare.

20-006.04 **Program Standards for Participation**: Subacute inpatient psychiatric services must have available licensed professionals and paraprofessionals with specific, identified duties and responsibilities to meet the acute and rehabilitative psychiatric needs of the clients being served. The following positions and services are required:

1. **Program/Clinical Director**: Must be a fully licensed clinician such as a psychiatric registered nurse (RN), psychiatric advanced practice registered nurse (APRN), or a licensed mental health practitioner (LMHP) who is skilled and knowledgeable to provide leadership and clinical direction to the treatment team.

   The duties and responsibilities of a program/clinical director are:
   a. Oversee, implement, and coordinate all treatment services and activities provided within the program 24 hours a day;
   b. Incorporate new clinical information and best practices into the program to assure effectiveness, viability and safety;
   c. Oversee the process to identify, respond to and report crisis situations on a 24-hour per day, 7-day per week basis;
d. Be responsible, (in conjunction with the medical director/attending psychiatrist) for the program’s clinical management by representation in the multidisciplinary treatment team meetings providing supervision to all program professionals and paraprofessional staff;

e. Communicate with the attending psychiatrist regarding individual treatment needs of the client;

f. Assure quality organization and management of clinical record documentation and confidentiality; and

g. Oversee and be responsible for the safety of clients and staff.

2. **Nursing Services**: All nursing services must be under the supervision of a registered professional nurse who is qualified by education and experience for the supervisory role. The number of registered professional nurses and other nursing personnel must be adequate to formulate and carry out the nursing components of a treatment plan for each client. The following standards must be met:

   a. The registered professional nurse supervising the nursing program must have a master’s degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or must be qualified by education and experience in the care of the individual with mental illness, and have demonstrated competence to:
      (1) Provide a comprehensive nursing assessment;
      (2) Participate in interdisciplinary formulation of treatment plans;
      (3) Provide skilled nursing care and therapy; and
      (4) Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client’s treatment plan;

   b. The staffing pattern must ensure the direct nursing coverage by a registered professional nurse 24 hours each day for:
      (1) Direct care; and
      (2) Supervising care performed by other nursing personnel;

   c. The number of registered professional nurses must be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out; and

   d. Registered professional nurses and other nursing personnel must be prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative services and transitioning to the most appropriate treatment service and community resources.

3. **Psychological Services**: Psychological services must be available through employment or contractual arrangement with a licensed psychologist. Psychological consultation must be available by a qualified licensed psychologist capable of providing diagnostic and treatment services. The following standards must be met:
a. Psychologists, consultants, and supporting personnel must be adequate in number and be qualified to assist in essential diagnostic formulations, and to participate in:
   (1) Program development and evaluation of program effectiveness;
   (2) Training and research activities;
   (3) Therapeutic interventions, such as milieu, individual, or group therapy; and
   (4) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs; and

b. Psychological testing must be ordered and directed by a psychiatrist.

4. Psychotherapy Services: Licensed clinicians must be employed in the facility to provide psychotherapy services according to the therapist’s scope of practice and according to the individualized treatment plan for the client. Licensed clinicians may include psychologists (Ph.D.), licensed mental health practitioners (LMHP), licensed alcohol and drug counselors (LADC), and advanced practice registered nurses (APRNS). Individual, group, and family psychotherapy must be available to each client and provided according to the client’s individual treatment plan. Services must be able to meet the unique needs of each client. Minimum requirements for psychotherapy offered and available to the client are:
   a. Individual therapy minimum two times weekly;
   b. Group therapy minimum three times weekly;
   c. Family therapy and intervention as appropriate and consented to by the client. With consent of the client, family therapy must be provided at the frequency and intensity to meet the unique needs of client and the family.

5. Licensed Addiction and Drug Abuse Services: Substance abuse assessment and treatment must be available to clients whose problems and symptoms indicate the possibility of or an established substance abuse problem, in addition to the primary psychiatric diagnosis. Licensed clinicians able to provide assessment and treatment of substance abuse problems must provide services according to and within their scope of practice. Usually, services are provided by a licensed alcohol and drug counselor.

6. Psycho Educational Services: Psychoeducational services, such as medication education, activities of daily living, social skill development must be offered in the program and providers must have psychoeducational services available to clients on a daily basis. Services may include education for diagnosis, treatment and relapse, life skills, medication management and symptom management. Services must be provided by a qualified professional or paraprofessional staff. Medication education must be provided by a registered nurse. Other psychoeducational services may be provided by a paraprofessional whose education and training provides competency to provide the service.

7. Case Management Services/Social Services Staff: Case Management/social services must be under the supervision of the program/clinical director. The case management/social service staff must be adequate in numbers and be qualified to fulfill responsibilities related to the specific needs of individual clients and their families. These responsibilities include, but are not limited to:
   a. The development of community resources;
   b. Consultation with other staff and community agencies;
c. Aggressive preparation for transitioning the client to the next level of service and safe living environment according to the treatment plan. Daily case management services are required for each client and must be summarized in the client's clinical record.

8. Ancillary Services: Recreational or activity therapy services must be available and offered to the client daily and directly supervised by the program/clinical director who has supervisory responsibility to the entire treatment team and the services they provide.

9. Psychiatric Technicians: The program must have available paraprofessional staff who are members of the multi-disciplinary team. The role and responsibility of the psychiatric technician is to:
   a. Intervene in the treatment milieu;
   b. Provide treatment interventions to the client which meet the specific psychiatric needs of the client as identified in the treatment plan;
   c. Demonstrate competency in applying the learned treatment interventions;
   d. Have direct knowledge of policies and procedures of the agency.

Psychiatric Technicians must have completed the program’s initial training program and continued ongoing training requirements. Seventy-five percent of the psychiatric technician staff must have completed a BS/BA degree in the Human Services field or have five years experience providing health care services.

20-006.05 Coverage Criteria for Subacute Inpatient Psychiatric Hospital Services: The Nebraska Medical Assistance Program covers subacute inpatient hospital psychiatric services for clients age 21 and over when the services meet the criteria in 471 NAC 20-001 and when the following requirements are met:

1. The attending psychiatrist must personally and face-to-face evaluate the client and document the psychiatric evaluation and diagnosis formulation within 24 hours of admission;
2. The attending psychiatrist assumes accountability to direct the care of the client at the time of admission;
3. The client must be treated by a psychiatrist personally and face-to-face a minimum of three times per week or more often, if medically necessary and the interaction must be documented in the client's clinical record;
4. The attending psychiatrist describes the medical necessity and active treatment requirements for the client;
5. The attending psychiatrist provides certification and recertification of the client's need for subacute inpatient psychiatric services; and
6. Clinical supervision of the multi-disciplinary treatment team and treatment team planning meetings as necessary to meet the individualized treatment needs of the client.
20-006.06  Treatment Planning:  An initial treatment plan must be implemented upon admission. The master/comprehensive treatment plan must be developed within 72 hours and reviewed by the treatment team a minimum of three times weekly. The master/comprehensive treatment plan must be developed from the recommendations made by the attending psychiatrist who has provided face-to-face evaluation of the client and the input from all other assessments completed following admission to subacute inpatient treatment services. Comprehensive treatment plans must meet medical necessity requirements.

Discharge planning must be a part of the comprehensive treatment plan. Discharge planning must be specific, realistic and individualized for the client from the time of admission and revised as medically necessary with treatment planning reviews.

20-006.07  Therapeutic Passes and Unplanned Leave of Absence:  Therapeutic passes for clients with a primary psychiatric diagnosis from a subacute inpatient psychiatric hospital are a part of treatment transitioning. Therapeutic passes are an essential part of the treatment of some psychiatric clients. Documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes.

Unplanned leaves of absence from subacute inpatient psychiatric care occur at times but are not reimbursable services to the program. The Department-contracted peer review organization or management designee must be notified immediately when the client returns.

20-006.08  Professional and Technical Components for Hospital Diagnostic and Therapeutic Services:  For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, see 471 NAC 10-003.05C, 10-003.05D, 10-003.05E, and 10-003.05F.

20-006.09  Criteria for Subacute Inpatient Psychiatric Hospital Services:  One or more of the following criteria must be present:

1. The client can benefit from longer-term evaluation, stabilization, and treatment services;
2. The client is at moderate to high risk to harm self/others;
3. The client has active symptomatology consistent with the current version of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM) (axes I-V) diagnoses;
4. The client has the ability to respond to intensive structured intervention services;
5. The client is at moderate to high risk of relapse or symptom reoccurrence;
6. The client has high need of professional structure and intervention services;
7. The client can be treated with short term intensive intervention services.
20-006.10 Prior Authorization Procedures: All subacute inpatient psychiatric admissions must be prior-authorized by the Department-contracted peer review organization or management designee. If the admission is approved, the Department-contracted peer review organization or management designee must assign a specific prior-authorization number. Providers must follow the Department-contracted peer review organization or management designee guidelines for facilitating prior authorization and continued stay review. Continued stay authorization is provided at a frequency appropriate for this short-term subacute program by the Department-contracted peer review organization or management designee.

20-006.11 Documentation in the Client's Clinical Record: The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to clients who receive services in a subacute inpatient psychiatric program. Clinical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the client is hospitalized. The clinical record must by legible and include:

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
3. The complaint of others regarding the client, as well as the client's comments;
4. The psychiatric evaluation, including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete neurological examination, when indicated, recorded at the time of the admitting physical examination;
6. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
7. The client's treatment plan and treatment plan reviews;
8. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes which are recorded by the psychiatrist or physician, nurse, social worker, and, when appropriate, others significantly involved in active treatment modalities. The frequency is determined by the condition of the client, but progress notes must be recorded daily by nursing staff, and at each contact by psychiatrist or physician and by all other treatment staff. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition;

12. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the current American Psychiatric Association's Diagnostic and Statistical Manual (DSM);

13. Therapeutic leave days prescribed by the psychiatrist under the treatment plan. The client's response to time spent outside the hospital must be entered in the client's hospital clinical record;

14. Transition and discharge planning documentation including relapse and crisis prevention planning;

15. Proof of family and community involvement;

16. The discharge summary, including a recapitulation of the client's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.

All documents from the client's medical record submitted to the Department must contain sufficient information for identification (that is, client's name, date of service, provider's name).

20-006.12 Certification and Recertification by Psychiatrists for Subacute Inpatient Hospital Psychiatric Services: The Department pays for covered subacute inpatient hospital psychiatric services only if a psychiatrist certifies, and recertifies at designated intervals, the medical necessity for the admission to and continued hospitalization for subacute inpatient psychiatric treatment services. Appropriate supporting material may be required. The psychiatrist's certification or recertification statement must document the medical necessity for the admission to and continued hospitalization for short-term inpatient psychiatric treatment, based on a current evaluation of the client's condition.

For clients admitted to a subacute program, a psychiatrist's certification by written order for admission is required at the time of admission.
20-006.12A Failure to Certify or Recertify: If a hospital fails to obtain the required certification and recertification statements for the client's stay, the Department will not make payment for the services that are not certified.

20-006.13 Hospital Utilization Review (UR): See 471 NAC 10-012 ff. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.

20-006.14 Payment for Subacute Inpatient Hospital Psychiatric Services: See 471 NAC 10-010.03D3.

20-006.14A Billing: Providers must submit claims for subacute inpatient hospital psychiatric services on Form HCFA-1450 (UB-04). Providers must enter the prior authorization number as required for subacute inpatient services.

20-006.15 Other Regulations: In addition to the policies regarding psychiatric services, all regulations in Title 471 NAC apply, unless stated differently in this section.

20-006.16 Limitations: For subacute inpatient hospital psychiatric services, the following limitations apply:

1. Care must be provided by and directly supervised by a licensed psychiatrist. The psychiatrist must be licensed in the state where the service is being delivered.
2. All subacute inpatient hospital psychiatric services must be prior-authorized; and
3. Payment for subacute inpatient hospital services is made according to 471 NAC 10-010.03D.

20-006.17 Documentation: Additional documentation from the client's medical record may be requested by the Department's psychiatric consultants prior to considering authorization of payment of subacute psychiatric care.
20-006.18 Emergency Protective Custody (EPC) in a Subacute Inpatient Program: A hospital may be reimbursed for clients under an EPC order in an acute care hospital without designated psychiatric beds for an average of three to five days, up to seven days under the following conditions:

1. The hospital is licensed by the Nebraska Department of Health and Human Services Division of Public Health;
2. The hospital is accredited by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association;
3. The admitting and attending physician is a psychiatrist;
4. The hospital provides a setting that is separate from the rest of the hospital activities and is a safe, therapeutic environment;
5. The hospital provides an active treatment program in the form of assessment and diagnostic interventions;
6. The hospital EPC program is approved by the Department’s Medicaid staff; and
7. The hospital EPC program meets all other standards for inpatient hospital psychiatric care.
20-007  Adult Inpatient Hospital Psychiatric Services: Inpatient hospital psychiatric services for clients 21 and over are medically necessary psychiatric services provided to an inpatient as defined in 471 NAC 10-000. The care and treatment of an inpatient with a primary psychiatric diagnosis must be under the direction of a psychiatrist or physician who meets the state’s licensing criteria and is enrolled as a provider with the Department with a primary specialty of psychiatry. Inpatient hospital psychiatric services must be prior-authorized by the Department-contracted peer review organization or management designee. In addition, out-of-state hospitalizations must be approved by the Department.

20-007.01 Provider Agreement: A hospital which provides inpatient psychiatric services shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider. The hospital shall submit with the provider agreement -

1. A complete description of the psychiatric program and the elements of the program (i.e., policies and procedures, staffing, services, etc.);
2. A statement of the total number of licensed psychiatric beds, as approved by the Nebraska Department of Health and Human Services, Division of Public Health or agency in the state in which the facility is located; a listing of the bed numbers for those licensed psychiatric beds; and the size of the proposed psychiatric unit;
3. Documentation that the inpatient program meets the family-centered, community-based requirements in 471 NAC 20-001;
4. A description of how family psychotherapy services will be provided;
5. A description of how the hospital services will interface with community services for discharge planning and service provision after discharge;
6. A copy of the most recent JCAHO or AOA accreditation survey; and
7. Any other information requested.

Any facility requesting a provider agreement shall make the facility available for an on-site review before issuance of a provider agreement.
20-007.02 Standards for Participation for Inpatient Hospital Psychiatric Service Providers: A hospital that provides inpatient hospital psychiatric services must meet the following standards for participation to ensure that payment is made only for active treatment. The hospital -

1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard - setting in that state;
3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the American Osteopathic Association (AOA);
4. Meets the requirements for participation in Medicare for psychiatric hospitals;
5. Has in effect a utilization review plan applicable to all Medicaid clients;
6. Must have medical records that are sufficient to permit the Department to determine the degree and intensity of treatment furnished to the client; and
7. Must meet staffing requirements the Department finds necessary to carry out an active treatment program (see 471 NAC 20-007.03).
8. Hospitals must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.
9. Hospitals must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.
10. The hospital must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

A distinct part of a hospital may be considered a psychiatric unit if it meets the standards for participation, even though the hospital of which it is a part does not.
20-007.03 Staffing Standards for Participation: The hospital must have staff adequate in number and qualified to carry out an active program of treatment for individuals who are provided services in the hospital. The hospital shall meet the following standards.

1. Hospital Personnel: Hospitals which provide inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required to carry out an intensive and comprehensive active treatment program that includes evaluation of individual and family needs; establishment of individual and family treatment goals; and implementation, directly or by arrangement, of a broad-range therapeutic program including, at least, professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each patient and their family. The following standards must be met:

   a. Qualified professional and technical personnel must be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include -
      (1) Laboratory, radiological, and other diagnostic tests;
      (2) Obtaining psychosocial data;
      (3) A complete family assessment (see 20-001 and 20-007.07, #7);
      (4) Carrying out psychiatric and psychological evaluations; and
      (5) Completing a physical examination, including a complete neurological examination when indicated, shortly after admission;

   b. The number of qualified professional personnel, including consultants and technical and supporting personnel, must be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals; and to plan, carry out, and periodically revise a treatment plan for each client based on scientific interpretation of -
      (1) The degree of physical disability and indicated remedial or restorative measures, including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions;
      (2) The degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found;
      (3) The capacity for social interaction, and appropriate nursing measures and milieu therapy to be undertaken, including group living experiences, occupational and recreational therapy, and other prescribed activities to maintain or increase the individual's capacity to manage activities of daily living; and
      (4) The environmental and physical limitations required to protect the client's health and safety with a plan to compensate for these deficiencies and to develop the client's potential for return to his/her own home, a foster home, a skilled nursing facility, a community mental health center, or other alternatives to full-time hospitalization.
2. **Director of Inpatient Psychiatric Services and Medical Staff:** Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or the equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of physicians must be adequate to provide essential psychiatric services. The following standards must be met:
   a. The clinical director, service chief, or equivalent must meet the training and experience requirements for a psychiatrist or a physician for NMAP;
   b. The medical staff must be qualified legally, professionally, and ethically for the positions to which they are appointed; and
   c. The number of physicians must be commensurate with the size and scope of the treatment program.
   d. The physician's personal involvement in all aspects of the client's psychiatric care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes).
   e. The physician must be available, in person or by telephone, to provide assistance and direction as needed.

3. **Availability of Physicians and Other Personnel:** Physicians and other appropriate professional personnel must be available at all times to provide necessary medical, surgical, diagnostic, and treatment services, including specialized services. If medical, surgical, diagnostic, and treatment services are not available within the hospital, qualified consultants or attending physicians must be immediately available, or a satisfactory arrangement must be established for transferring patients to a general hospital certified for Medicare.

4. **Nursing Services:** Nursing services must be under the direct supervision of a registered professional nurse who is qualified by education and experience for the position. The number of registered professional nurses, licensed practical nurses, and other nursing personnel must be adequate to formulate and carry out the nursing components of a treatment plan for each client. The following standards must be met:
   a. The registered professional nurse supervising the nursing program must have a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or must be qualified by education or experience in the care of the mentally ill, and have demonstrated competence to -
      (1) Participate in interdisciplinary formulation of treatment plans; 
      (2) Give skilled nursing care and therapy; and
      (3) Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client's treatment plan;
b. The staffing pattern must ensure the availability of a registered professional nurse 24 hours each day for -
   (1) Direct care;
   (2) Supervising care performed by other nursing personnel; and
   (3) Assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the client's needs and the preparation and competence of the nursing staff available;

c. The number of registered professional nurses, including nurse consultants, must be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out; and

d. Registered professional nurses and other nursing personnel must be prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.

5. Psychological Services: The psychological services must be under the supervision of a licensed psychologist. The psychology staff, including consultants, must be adequate in numbers and be qualified to plan and carry out assigned responsibilities. The following standards must be met:
   a. The psychology department or service must be under the supervision of a licensed psychologist;
   b. Psychologists, consultants, and supporting personnel must be adequate in number and be qualified to assist in essential diagnostic formulations, and to participate in -
      (1) Program development and evaluation of program effectiveness;
      (2) Training and research activities;
      (3) Therapeutic interventions, such as milieu, individual, or group therapy; and
      (4) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs;
   c. Psychotherapy must be ordered and directed by a physician; and

6. Social Work Services and Staff: Social work services must be under the supervision of a qualified social worker. The social work staff must be adequate in numbers and be qualified to fulfill responsibilities related to the specific needs of individual clients and their families, the development of community resources, and consultation with other staff and community agencies. The following standards must be met:
   a. The director of the social work department or service must have a master's degree from an accredited school of social work and must meet the experience requirements for certification by the Academy of Certified Social Workers and, effective 9-1-94, must be licensed by the Nebraska Department of Health and Human Services, Division of Public Health as a mental health practitioner; and
b. Social work staff, including other social workers, consultants, and other assistants or case aides, must be qualified and numerically adequate to -

(1) Provide psychosocial data for diagnosis and treatment planning, and for direct therapeutic services to patients, patient groups, or families; to develop community resources, including family or foster care programs; to conduct appropriate social work research and training activities; and to participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.

7. Qualified Therapists, Consultants, Volunteers, Assistants, Aides: Qualified therapists, consultants, volunteers, assistants, or aides must be sufficient in number to provide comprehensive therapeutic activities, including occupational, recreational, and physical therapy, as needed, to ensure that appropriate treatment is provided to each client, and to establish and maintain a therapeutic milieu. The following standards must be met:

a. Occupational therapy services must be provided preferably under the supervision of a graduate of an occupational therapy program approved by the Council on Education of the American Medical Association who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health or is eligible for the National Registration Examination of the American Occupational Therapy Association. In the absence of a full-time, fully-qualified occupational therapist, an occupational therapy assistant may function as the director of the activities program with consultation from a fully-qualified occupational therapist;

b. When physical therapy services are offered, the services must be given by or under the supervision of a qualified physical therapist who is a graduate of a physical therapy program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent and is licensed by the Nebraska Department of Health and Human Services, Division of Public Health. In the absence of a full-time, fully-qualified physical therapist, physical therapy services must be available by arrangement with a certified local hospital, or by consultation or part-time services furnished by a fully-qualified physical therapist;

c. Educational Program Services: Services, when required by law, must be available. Educational Services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not covered for payment by the Nebraska Medical Assistance Program;

d. Recreational or activity therapy services must be available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs;

e. Other occupational therapy, recreational therapy, activity therapy, and physical therapy assistants or aides must be directly responsible to qualified supervisors and must be provided special on-the-job training to fulfill assigned functions;
f. The total number of rehabilitation personnel, including consultants, must be sufficient to -
   (1) Permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences; and
   (2) Maintain all daily scheduled and prescribed activities, including maintenance of appropriate progress records for individual clients; and

   g. Volunteer service workers must be -
   (1) Under the direction of a paid professional supervisor of volunteers;
   (2) Provided appropriate orientation and training; and
   (3) Available daily in sufficient numbers to assist clients and their families in support of therapeutic activities.

20-007.04 Coverage Criteria for Inpatient Hospital Services: The Nebraska Medical Assistance Program covers inpatient hospital psychiatric services for clients age 21 and over when the services meet the criteria in 471 NAC 20-001 and when the following requirements are met:

1. The attending physician must personally and face-to-face evaluate the client and write the psychiatric evaluation and diagnosis formulation;
2. The client must be treated by a physician personally and face-to-face six out of seven days and the interaction must be documented in the client's clinical record;
3. A psychiatrist or physician for NMAP serves as the attending physician and defines the medical necessity and active treatment requirements noted in 471 NAC 20-001, "General Requirements";
4. The treatment plan must be developed and supervised by a multi-disciplinary team under the direction and supervision of the physician. It must be implemented upon admission and must be reviewed every 30 days or more often if medically necessary by the multi-disciplinary team. Treatment plans must meet the medical necessity and active treatment requirements in 471 NAC 20-001;
5. Therapeutic passes for clients with primary psychiatric diagnoses from hospitals which provide psychiatric services. Therapeutic passes are an essential part of the treatment of some psychiatric clients. Documentation of the client’s continued need for psychiatric care must follow the overnight therapeutic passes. Payment for hospitalization after a second pass is not available based on medical necessity. The hospital is not paid for therapeutic passes or leave days;
6. Unplanned leaves of absence from inpatient and psychiatric hospital care: The hospital is not paid for unplanned leave of absence days. The Department contracted peer review organization or management designee must be notified immediately when the client returns. Admission criteria will be applied. If approved, a new validation number will be issued to cover the days beginning with the day of return.

20-007.04A Professional and Technical Components for Hospital Diagnostic and Therapeutic Services: For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, see 471 NAC 10-003.05C, 10-003.05D, 10-003.05E, and 10-003.05F.
20-007.05 Admission Criteria for Inpatient Hospital Psychiatric Services: One or more of the following problems must be present:

1. The patient needs a specific form of psychiatric treatment that can only be provided in the hospital and the structured environment of the hospital is necessary for the client's treatment;
2. Specific observations are needed for evaluation and disposition;
3. Specific observations are needed for following treatment, or control of behavior is necessary for effective somatic therapy or psychotherapy;
4. The client's disorder is a serious threat to his/her adaptation to life and continuing developmental process, and hospitalization at this time is necessary to control this factor;
5. The patient is experiencing psychiatric symptoms, the magnitude of which is not tolerable to self or society and that cannot be alleviated through treatment;
6. The patient is unable to be cared for by self or others, due to psychiatric disorder;
7. All patients must require and receive "active treatment" as defined in 42 CFR 441.154, which is available only in an inpatient setting. Exception: Clients are 65 and older in an IMD (see 471 NAC 20-008); or
8. Ambulatory care services in the community do not meet the treatment needs of the client. Note: In those communities where outpatient resources are not available, the community pattern of referral must be used when appropriate.

20-007.05A Guidelines for Interpretation: Admission of an individual age 21 and older to an acute care facility or an acute level of care may be made only after all resources at a less restrictive level have been explored and deemed inappropriate.

The following will not be accepted as adequate medical indicators for hospital inpatient admission:

1. Non-availability of group home, halfway house, residential treatment or other placement alternatives;
2. Admission to support or arrange placement in group home, halfway house, or residential treatment;
3. Admission solely for emergency placement or protective custody;
4. Admission due to failure of current placement;
5. Reason for acute level of care is to obtain Medicaid benefits that would otherwise not be reimbursed;
6. Admission to avoid placement in the criminal justice system;
7. Admission for conduct disorders or behavioral issues that do not demonstrate an imminent danger to self or others;
8. Social and family problems; and
9. Psychometric evaluation including mental retardation and learning disabilities.
20-007.05A1  Patient Assessment: Admission to an acute care facility must meet elements #1 and #2 (listed below) plus at least one other element from this patient assessment section. The additional element must be as a result of the major psychiatric disorder referred to in element #1. In addition, one element from the acute services section must be met.

Elements #1 and #2 must be met on all admissions.

1. Documented evidence of a major psychiatric disorder that necessitates 24-hour medical supervision and daily physician contact.

2. Documented initial treatment plan with provisions for -
   a. Resolution of acute medical problems;
   b. Evaluation of, and needs assessment for, medications;
   c. Protocol to ensure patient's safety;
   d. Discharge plan initiated at the time of admission.

Plus one of the following:

3. Demonstrates imminent danger to self or others at the time of admission evidenced by at least one of the following:
   a. Suicide attempt or specific suicide plan with access to means;
   b. Danger to others through a specific action or activity;
   c. Command hallucination with suicidal or homicidal content;
   d. Hallucinations, delusional behavior, or other bizarre psychotic behavior.

4. Presence of other behavior/symptoms to such a degree or in such a combination that acute care is the least restrictive treatment available as demonstrated by at least one of the following:
   a. Physical aggression toward family, peers, or coworkers which could not be considered self protective;
   b. Explosive behavior without provocation or serious loss of impulse control;
   c. Dangerous, assaultive, uncontrolled or extreme impulsive behavior which puts the patient at significant risk, e.g., running into traffic, playing/setting fires, self-abuse, and which cannot be prevented in a non-acute setting;
   d. Severe impairment in concentration and/or hyperactivity;
   e. Behaviors consistent with an acute psychiatric disorder which may include significant mental status changes; and there is documented evidence that no medical condition would account for the symptoms;

5. Severe impairment in psychosocial functioning as demonstrated by at least one of the following:
   a. Psychotic behavior, delusions, paranoia, or hallucinations;
   b. Severe decompensation and interference with baseline functioning;
6. Documented failure of current intensive outpatient treatment including two or more of the following indications:
   a. Intensification or perseverance of severe psychiatric symptoms;
   b. Noncompliance with medication regime;
   c. Lack of therapeutic response to medication;
   d. Lack of patient participation in or response to outpatient treatment modalities;
7. Admissions ordered by the court will be covered when accompanied by substantiation of medical necessity.

Documentation supports the need for controlled, clinical observation and psychiatric evaluation, where acute care is the least restrictive treatment alternative.

20-007.05A2 Acute Services:

Justification for Continued Stay: The patient must meet elements #1 and #2 plus two elements from 2 through 7 for the approval of continued stay.

* Elements #1 and #2 must be met at all continued stay reviews.

1. Evidence of a major psychiatric disorder that necessitates 24-hour medical supervision and family physician contact.
2. A comprehensive treatment plan/clinical pathway of inpatient care must be completed within 72 hours of admission and implemented to facilitate the patient's progression toward living in a less supervised setting. Documentation must support the patient's and/or family's active involvement with the treatment goals and with revisions in the treatment plan as appropriate based on the patient's progress or lack of progress.

* Plus two of the following:

3. Isolation, seclusion, or restraint procedures within the last 72 hours requiring 24-hour medical supervision and supported by medical record documentation.
4. Continuing evidence of symptoms and/or behaviors reflecting significant risk, imminent danger, or actual demonstrated danger to self or others; requiring suicide/homicide precautions (1:1), close observation, step down precautions (every 15-60 minute checks).
5. Monitoring/adjustment of psychotropic medication(s) related to lack of therapeutic effect/complication(s) in the presence of complicating medical and psychiatric conditions necessitating 24-hour medical supervision and supported by medical record documentation.
6. Persistence of psychotic symptoms and continued temporary (not chronic) inability of the patient to perform the activities of daily living or meet their basis needs for nutrition and safety due to a psychiatric disorder or the temporary mental state of the patient.

7. Continued need for 24-hour medical supervision, reevaluation and/or diagnosis of a patient exhibiting behaviors consistent with acute psychiatric disorder. Referral for physician review is necessary if symptoms are unimproved or worse within any seven-day interval.

20-007.05B Signs and Symptoms: In addition to the admission criteria, one or more of the following signs or symptoms of the problem must be present:

1. A suicide attempt that requires acute medical intervention or suicidal ideation with a lethal plan and the means to carry out this plan;
2. Psychiatric decompensation to a level in which the client is not able to communicate or perform life-sustaining activities of daily living;
3. Delusions or hallucinations that significantly impair the client's ability to communicate or perform life-sustaining activities of daily living;
4. Catatonia;
5. The presence of combined illnesses where neurological or other disease process coexists with a psychiatric disturbance, demanding special diagnostic or treatment interventions, which exceed non-hospital capacity;
6. Aggression to others causing physical injury or homicidal ideation with a lethal plan and the means to carry out the plan, that is the result of a severe emotional psychiatric decompensation; and
7. Medication initiation or change when the client has a documented history of reactions to psychotropic medications that have resulted in the need for acute medical care in a hospital or an emergency room.

20-007.06 Prior Authorization Procedures: All inpatient admissions must be prior-authorized by the Department-contracted peer review organization or management designee. Each client will have a specific prior-authorization number assigned by the Department contracted peer review organization or management designee if the admission is approved. Providers should follow the Department's contracted peer review organization or management designee guidelines on facilitating prior authorization.
20-007.07 Documentation in the Client's Clinical Record: The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to clients who receive services in the hospital. For inpatient hospital psychiatric services, clinical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the client is hospitalized. The medical record must be legible and include: 

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
3. The complaint of others regarding the client, as well as the client's comments;
4. The psychiatric evaluation, including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete neurological examination, when indicated, recorded at the time of the admitting physical examination;
6. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
7. A family assessment as described in 471 NAC 20-001;
8. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
9. The client's treatment plan and treatment plan reviews;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes which are recorded by the psychiatrist or physician, nurse, social worker, and, when appropriate, others significantly involved in active treatment modalities. The frequency is determined by the condition of the client, but progress notes must be recorded daily by nursing staff, and at each contact by psychiatrist or physician and by all other therapeutic staff (such as O.T., R.T.). Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition;
12. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the current American Psychiatric Association's Diagnostic and Statistical Manual;

13. Therapeutic leave days prescribed by the psychiatrist under the treatment plan. The client's response to time spent outside the hospital must be entered in the client's hospital clinical record;

14. Transition and discharge planning documentation;

15. Proof of family and community involvement;

16. A copy of the MC-14 certification; and

17. The discharge summary, including a recapitulation of the client's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.

All documents from the client's medical record submitted to the Department must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

20-007.08 Certification and Recertification by Psychiatrists for Inpatient Hospital Psychiatric Services

20-007.08A Certification and Recertification by Psychiatrists: The Department pays for covered inpatient hospital psychiatric services only if a psychiatrist or physician certifies, and recertifies at designated intervals, the medical necessity for the services of the hospital inpatient stay. Appropriate supporting material may be required. The psychiatrist's or physician's certification or recertification statement must document the medical necessity for the admission to and continued hospitalization for inpatient psychiatric treatment, based on a current evaluation of the client's condition.

For clients admitted to a hospital, a psychiatrist's or physician's certification by written order for admission is required at the time of admission for inpatient services.
20-007.08B  Failure to Certify or Recertify:  If a hospital fails to obtain the required certification and recertification statements in an individual case, the Department shall not make payment for the case.

20-007.09  Hospital Utilization Review (UR):  See 471 NAC 10-012. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.

20-007.10  Payment for Inpatient Hospital Psychiatric Services:  See 471 NAC 10-010.03.

20-007.10A  Billing:  Providers shall submit claims for inpatient hospital psychiatric services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

20-007.11  Other Regulations:  In addition to the policies regarding psychiatric services, all regulations in the Nebraska Department of Health and Human Services Manual apply, unless stated differently in this section. For inpatient services provided by an IMD, public or private, see 471 NAC 20-008.

20-007.12  Limitations:  For inpatient hospital psychiatric services, the following limitations apply:

1.  Care must be supervised by a psychiatrist or physician. All inpatient hospital services must be prior-authorized; and
2.  Payment for inpatient hospital services is made according to 471 NAC 10-010.03.
20-007.13 Form Completion: Inpatient hospital psychiatric service providers shall:

1. Complete Form MC-20 and be approved and enrolled with the Department as a provider of inpatient hospital psychiatric services (class of care 06);
2. Submit all claims for inpatient hospital services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837);
3. Enter the review number from the Department contracted peer review organization or management designee as required.

Payment for approved services is made to the hospital.

20-007.14 Exceptions: Additional documentation from the client's medical record may be requested by the Department's psychiatric consultants prior to considering authorization of payment.

20-007.15 Emergency Protective Custody (EPC) in an Acute Care Hospital: Emergency Protective Custody (EPC) Services may be reimbursed in an acute care hospital without licensed psychiatric beds for an average of three to five days, up to seven days under the following conditions:

1. The hospital is licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
2. The hospital is accredited by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association;
3. The admitting and attending physician is a psychiatrist;
4. The hospital provides a setting that is separate from the rest of the hospital activities and is a safe, therapeutic environment;
5. The hospital provides an active treatment program in the form of assessment and diagnostic interventions;
6. The hospital EPC program is approved by the Department's Medicaid staff; and
7. The hospital EPC program meets all other standards for inpatient hospital psychiatric care.

The exception for EPC services is available only to hospitals that do not have licensed psychiatric beds.
20-008.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) covers IMD services, for clients 65 and over, under 42 CFR 431.620(b); 435.1009; 440.140; 440.160; Part 441, Subparts C and D; Part 447, Subparts B and C; Part 456, Subparts D and I; and Part 482. The Department provides IMD services under the Family Policy Act, Sections 43-532 through 534, Reissue Revised Statute of Nebraska, 1943.

20-008.02 Definition of an IMD: 42 CFR 435.1009 defines an IMD as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." This is limited to free-standing facilities which are not excluded units of acute care hospitals.

20-008.03 Standards for Participation: To participate in the NMAP, the IMD must -

1. Be in conformity with all applicable federal, state, and local laws;
2. Be licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or the licensing agency in the state where the IMD is located;
3. Be certified as meeting the conditions of participation for hospitals in 42 CFR Part 482;
4. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and submit a copy of the most recent accreditation survey with Form MC-20;
5. Meet the definition of an IMD as stated in 471 NAC 20-008.02 (above);
6. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
7. Meet the current JCAHO or AOA standards of care; and
8. Meet all requirements in 471 NAC 20-001 except active treatment.

20-008.03A Provider Agreement: The provider shall complete Form MC-20 and submit the form, along with a copy of its current JCAHO or AOA accreditation survey, program, policies, and procedures to the Department to enroll in NMAP as a provider. If approved, the Department notifies the IMD of its provider number.

20-008.03B Annual Update: With the annual cost report, the provider shall submit a copy of all program information, their most recent license and accreditation certificates, and any other information specifically requested by the Department. Claims will not be paid if this has not been received and approved. This information must be submitted with a new copy of Form MC-20.
20-008.03C Monthly Reports: The IMD shall submit a monthly report to the Division of Medicaid and Long-Term Care. The report must contain -

1. The names of all Medicaid clients admitted or discharged during the month; and
2. The date of each Medicaid client's admission or discharge.

The report must be submitted by the 15th of the following month.

20-008.03D Record Requirements: The regional center (or the local office for a client in a private facility) shall enter the Form MC-9H document number in Form Locator 63 on each Form CMS-1450 or standard electronic Health Care Claim: Institutional transaction that is submitted to the Department.

Transfer to another IMD or readmission constitutes a new admission for the receiving facility.

20-008.03D1 An Individual Who Applies For NMAP While in the IMD: For an individual who applies for NMAP while in the IMD, the certification must be -

1. Made by the team that develops the individual plan of care (see 471 NAC 20-008.10);
2. Cover any period before application for which claims are made.

When Medicaid eligibility is determined, authorization for previous and continued care must be obtained from the Department contracted peer review organization or management designee.

20-008.04 General Definitions: The following definitions are used in this section:

Interdisciplinary Team: The team responsible for developing each client's individual plan of care. The team must include a board-eligible or board-certified psychiatrist. The team must also include at least two of the following:

1. A Licensed Mental Health Practitioner;
2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;
3. An occupational therapist who is licensed, if required by state law, and who has specialized training or one year's experience in treating mentally ill individuals; or
4. A licensed psychologist.
Inpatient Hospital Services for Individuals Age 65 or Older in Institutions for Mental Disease (IMD's): Services provided under the direction of a psychiatrist for the care and treatment of clients age 65 and older in an institution for mental disease that meets the requirements of 42 CFR 440.140.

Inspection of Care Team: The Department's inspection of care team, consisting of a psychiatrist knowledgeable about mental institutions, a qualified registered nurse, and other appropriate personnel as necessary who conduct inspection of care reviews under 42 CFR 456.600-614 and 471 NAC 20-001.20.

Medical Review Organization: A review body contracted by the Department, responsible for pre-admission certification and concurrent and retrospective reviews of care.

20-008.05 Admission Criteria: See 471 NAC 20-007.05.

20-008.06 Signs and Symptoms: In addition to the admission criteria, one or more of the following signs or symptoms of the problem must be present:

1. A suicide attempt that requires acute medical intervention or suicidal ideation with a lethal plan and the means to carry out this plan;
2. Psychiatric decompensation to a level in which the client is not able to communicate or perform life-sustaining activities of daily living;
3. Delusions or hallucinations that significantly impair the client's ability to communicate or perform life-sustaining activities of daily living;
4. Catatonia;
5. The presence of combined illnesses where neurological or other disease process coexists with a psychiatric disturbance, demanding special diagnostic or treatment interventions, which exceed non-hospital capacity;
6. Aggression to others causing physical injury or homicidal ideation with a lethal plan and the means to carry out the plan, that is the result of a severe emotional psychiatric decompensation; and
7. Medication initiation or change when the client has a documented history of reactions to psychotropic medications that have resulted in the need for acute medical care in a hospital or an emergency room.
**20-008.07 Prior Authorization and Initial Certification Procedures**: IMD services for clients age 65 or older must be prior-authorized as follows:

1. Admissions must be prior-authorized by the Department's contracted peer review organization or management designee. Providers should follow the Department contracted peer review organization or management designee guidelines on facilitating prior authorization. The MC-14 received from the peer review organization or management designee must be maintained in the client's medical record;

2. A psychiatrist shall pre-certify, at the time of admission, that the client requires inpatient services in a psychiatric hospital. The psychiatrist shall complete, sign, and date Form MC-14 within 48 hours after admission or at the time of application for medical assistance if this date is later than the date of admission. The 48-hour period does not include weekends or holidays. Copies of the admission notes and plan of care may be attached to the signed and dated Form MC-14 to certify that inpatient services are or were needed;

3. The facility shall contact the client's local office for determination of medical eligibility. The local office shall respond to the facility with:
   a. The medical eligibility effective date; and
   b. The date eligibility was determined, if this date is later than the date of admission;

4. The facility shall complete Form MC-9H, attach a copy of the completed Form MC-14, and forward to the Division of Medicaid and Long-Term Care. The facility shall retain the original copy of Form MC-14 in the client's medical record;

5. The Division of Medicaid and Long-Term Care shall review Form MC-14 and approve or reject the Form MC-14 findings within 15 days;

6. If rejected, the Division of Medicaid and Long-Term Care shall return all forms to the facility with an explanation of the rejection;

7. If approved, the Division of Medicaid and Long-Term Care shall complete Block #11 and the signature Block #18 of Form MC-9H. The white copy is retained in Central Office. The Division of Medicaid and Long-Term Care shall send the pink and gold copies to the facility and the yellow copy to the local office;

8. The document number on Form MC-9H must be entered in Form Locator 63 on each Form CMS-1450 or standard electronic Health Care Claim: Institutional transaction submitted to the Department; and

9. When the client is discharged or expires, the facility shall complete Form MC-10 to close the authorization. The facility shall forward the white copy to the Division of Medicaid and Long-Term Care and the yellow copy to the local office, and retain the pink and gold copies. Within 48 hours after a client is discharged or expires, the facility shall notify the local office in the client's county of finance.
20-008.08  **Transfers:** Transfer to another IMD or a readmission constitutes a new admission for the receiving facility. This procedure must be followed for each transfer or readmission.

20-008.09  **Sixty-Day Recertification:** A psychiatrist shall recertify, in the client's record, the client's need for continued care in a mental hospital or need for alternative arrangements at least every 60 days after the initial certification.

20-008.10  **Interdisciplinary Plan of Care:** The psychiatrist and the facility interdisciplinary team shall develop and implement an individual written plan of care for each client within 48 hours after the client's admission. This plan of care must be placed in the client's chart when completed. The written plan of care must include -

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the client's functional level;
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 recommended for the client's health and safety.
5. Plans for continuing care, including review and modification of the plan of care;
6. Appropriate medical treatment in the IMD every 60 days;
7. Appropriate social services every 60 days;
8. Family involvement; and
9. Plans for discharge, including referrals for outpatient follow-up care.

This requirement is met by completion of Form MC-14, which is retained in the client's record.

20-008.11  **Facility Interdisciplinary Plan of Care Team Review:** The attending or staff psychiatrist and other personnel involved in the client's care shall review each plan of care at least every 90 days. The client's record must contain documentation of the 90-day interdisciplinary team review.
20-008.12 Admission Evaluation: IMD staff shall develop an admission evaluation for each client within 30 days after the client's admission. This evaluation must be placed in the client's record when completed. The admission evaluation must include -

1. The Form MC-14;
2. A medical evaluation, including -
   a. Diagnosis;
   b. Summary of current medical findings;
   c. Medical history;
   d. Mental and physical functional capacity;
   e. Prognosis;
   f. The psychiatrist's recommendation concerning the client's admission to the mental hospital or the client's need for continued care in the mental hospital, if the client applies for NMAP while in the mental hospital;
3. A psychiatric evaluation;
4. A social evaluation;
5. An initial plan of care sufficient to meet the client's needs until the facility interdisciplinary team has developed the individual written plan of care.

20-008.13 Discharge Planning: The IMD shall make available to the psychiatrist current information on resources available for continued out-of-hospital care of patients and shall arrange for prompt transfer of appropriate medical and nursing information to ensure continuity of care upon the client's discharge. Under 42 CFR 441.102, when the client is approved for an alternate plan of care, the IMD is responsible for discharge planning. In cooperation with community regional mental health programs, the IMD shall -

1. Initiate alternate care arrangements;
2. Assist in client transfer; and
3. Follow-up on the client's alternate care arrangements.

When the client is being transferred to a long term care facility (NF or ICF/MR), the facility's staff must be included in the discharge process and must receive appropriate and adequate medical and nursing information to ensure continuity of care. The IMD shall also contact the client's local office.
20-008.14 Payment for IMD Services: See 471 NAC 10-010.03 ff.

20-008.14A Therapeutic Passes from IMD Settings: For some psychiatric clients, therapeutic passes are an essential part of treatment. For those clients, documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes. Payment for hospitalization beyond a second pass is not available due to medical necessity.

20-008.14B Unplanned Leaves of Absence from IMD Settings: Payment for hospitalization during an unplanned leave of absence is not available. The Department contracted peer review organization or management designee must be notified immediately when the client returns. Admission criteria will be applied. If approved, a new validation number will be issued to cover the days beginning with the day of return.
CHAPTER 21-000  REHABILITATION CARE IN HOSPITALS

21-001  Definitions

Activities of Daily Living: Activities performed by the client relating to self-care, such as bathing, continence, eating, dressing, grooming, mobility, toileting, and transferring.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

Initial Evaluation: See 471 NAC 21-003.02A

Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located, and distinct parts as defined in these regulations.

Rehabilitation Services: Any medical or remedial services recommended by and within the scope of practice under state law of a physician, for maximum reduction of physical or mental disability and restoration of a client to the client’s best possible functional level.

Rehabilitation Team: A multidisciplinary coordinated team, comprised of individuals described in 471 NAC 21-003.02(i)-(vii), which is responsible for performing the initial evaluation, determining the extent to which rehabilitation is possible, identifying rehabilitation goals, and developing the rehabilitation program.

21-002 Provider Requirements

21-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of rehabilitation services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in 471 NAC Chapter 21, the individual provider participation requirements in 471 NAC Chapter 21 shall govern.

21-002.02 Specific Provider Requirements: Rehabilitation services must be provided in a hospital or a distinct part of a hospital that:

i. Provides rehabilitation services;
ii. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or, if the hospital is located in another state, the authority responsible for licensing or formal approval in that state;
iii. Has licensed and certified rehabilitation beds;
iv. Meets the requirements for participation in Medicare for rehabilitation hospitals; and
v. Has in effect a utilization review plan which applies to all Medicaid clients.
21-002.02A  Provider Agreement:  A hospital which provides rehabilitation services shall complete and sign Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider.  Each hospital shall have a separate provider agreement (and a separate provider number) for rehabilitation services.  The hospital shall submit a description of the rehabilitation program with the provider agreement.

21-002.02A1  Out-of-State Hospital Provider Agreement: In addition to a completed and signed Form MC-20, an out-of-state hospital shall also submit documentation of its certification/accreditation status from the state survey agency in the state where the hospital is located.  The Department will not process claims received from an out-of-state hospital until all information required under this section has been received.

Also see 471 NAC 10-010.03J, Out-of-State Hospital Rates, and 10-010.06G, Payment to an Out-of-State Hospital for Outpatient Hospital and Emergency Room Services.

21-002.02B  Hospital Level of Rehabilitation Care: The Rehabilitation hospital must provide a hospital level of rehabilitative care.  Hospitals with a significant number of rehabilitation team members working on a part time basis must provide evidence to establish that the hospital did, in fact, provide a hospital level of rehabilitative care.  Evidence documenting the hospital level of rehabilitative care includes, but is not limited to:

1. Verification that team conferences were held at least once every two weeks;
2. Verification that there was a need for, and involvement of, various allied health professionals; and,
3. Verification of the intensity of the rehabilitative program.

21-003  Service Requirements

21-003.01  General Requirements

21-003.01A  Medical Necessity: Rehabilitation services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A.

21-003.01B  Prior Authorization of Medical Rehabilitation Care: Medicaid requires prior authorization of all medical inpatient rehabilitation services to determine the medical necessity, appropriateness of setting, and length of stay.  Prior authorization functions, admission reviews, concurrent reviews, and retrospective prepayment reviews are conducted by the peer review organization (PRO), an entity contracted with Medicaid to perform these services.  The PRO also performs reconsideration reviews of inpatient hospital denials when requested by the provider.

21-003.01C  Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

21-003.01C1  Delayed Enrollment: When a client is in an acute care medical or rehabilitation facility prior to the client’s enrollment in Managed Care, the effective date of
enrollment is delayed until the client is discharged from the facility or transferred to a lower level of care. See 482 NAC 2-002.05D.

21-003.01D HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

21-003.02 Covered Services: Medicaid covers rehabilitation services for patients requiring a hospital level of care, and a rehabilitation program which incorporates a multidisciplinary coordinated team approach to upgrade his/her ability to function as independently as possible. A program of this scope usually includes:
   i. Intensive skilled rehabilitation nursing care;
   ii. Physical therapy;
   iii. Occupational therapy; and
   iv. If needed, speech therapy;
   v. Nursing staff to provide general nursing services, and support the other disciplines by monitoring the patient's activities on the nursing floor to ensure that s/he participates in carrying out the activities of daily living utilizing the training received in therapy;
   vi. Ongoing general and, as needed, direct supervision of a physician with special training or experience in the field of rehabilitation (For coverage limitations, billing, and payment of physicians services, see 471 NAC 18-000.); and,
   vii. If needed, a psychologist and/or social worker to help resolve any psychological and social problems which are impeding rehabilitation. (For coverage limitations, billing, and payment of psychological services, see 471 NAC 20-000 and/or 32-000.)

21-003.02A Rehabilitation Evaluation: When a client is admitted to the hospital for rehabilitation care, an assessment must be made of his/her:
   i. Medical condition;
   ii. Functional limitations;
   iii. Prognosis;
   iv. Possible need for corrective surgery;
   v. Attitude toward rehabilitation; and
   vi. The existence of any social problems affecting rehabilitation.

After these assessments are made, the physician, in consultation with the rehabilitation team, decides whether rehabilitation is possible; what the reasonable rehabilitation goals are; and what type of rehabilitation program is required to achieve these goals.

21-003.02A1 Limitations to Coverage of the Initial Evaluation:

21-003.02A1a Duration of Evaluation: When more than 10 days are required to complete the initial evaluation, the Department will carefully review the case to ensure that the additional time was necessary. The Department may request, and the hospital shall submit, documentation showing the necessity of the additional time. Inpatient hospital care is required for this period, and covered under Medicaid if the client's condition warrants a multidisciplinary team evaluation.

21-003.02A1b Identical or Similar Admission Conditions: If, during a previous hospital stay, the client completed a program for essentially the same condition for
which inpatient hospital care is now being provided, the Department covers the initial evaluation period only if:

i. A change in circumstances has occurred which makes an evaluation reasonable and necessary; or,

ii. The subsequent admission is to an institution utilizing advanced techniques or technology not available in the first institution.

21-003.02A1c Dementia or Senility: In view of the client's limited rehabilitation potential, a multidisciplinary team evaluation is not considered reasonable and necessary for a client who is demented or severely senile.

21-003.02A2 Mental Confusion: Medicaid does not cover hospitalization for rehabilitation following an evaluation if mental confusion with an inability to learn is the only existing disability. Alternatively, the fact that an individual is "confused" is not a basis for concluding that a multidisciplinary team evaluation is not warranted.

21-003.02B Rehabilitation Program: Medicaid covers hospitalization in cases where the rehabilitation team determines, after the initial evaluation, that a significant practical improvement can be expected in a reasonable period of time. Rehabilitation goals must be realistic and reasonable. Vocational rehabilitation is generally not considered a realistic goal for most clients receiving rehabilitation services under Medicaid. For the majority of clients, the most realistic rehabilitation goal is self-sufficiency in:

1. Bathing;
2. Ambulation;
3. Toileting;
4. Eating;
5. Dressing;
6. Homemaking; or
7. Sufficient improvement in the areas of self-sufficiency to allow the client to live in the community with assistance rather than in an institution.

In assessing the reasonableness of the established goal or the likelihood that the rehabilitation goal can be achieved in a reasonable period of time, considerable weight must be given to the rehabilitation team's judgment, except where experience indicates that in a significant number of cases the team's judgment has proven to be unreliable. An expectation of the attainment of complete independence in the activities of daily living is not necessary, but there must be an expectation of an improvement that would be of a practical benefit to the client.

21-003.02C Team Conferences: Rehabilitation team conferences must be held at least every 2 weeks to:

1. Assess the individual's progress or the problems impeding progress;
2. Consider possible resolutions to the problems;
3. Reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation;
4. Reassess the need for any adjustment in these goals or in the prescribed treatment program; and
5. Develop discharge plans.
Team conferences may be a formal or informal, but must involve interactive discussion regarding the patient. The decisions made during conferences must be recorded in the patient's clinical record. The Department may request, and the hospital shall provide, documentation of team conferences.

21-003.02D Discharge: Medicaid covers a maximum of 3 days to discharge the client. If more than 3 days is needed to safely discharge the client, payment for additional days will be made only when adequate justification for the delayed discharge is submitted to the Department.

21-003.03 Non-Covered Services

21-003.03A Poor Candidate for Rehabilitation: When the initial evaluation results in a conclusion that the client is a poor candidate for rehabilitation care, Medicaid limits coverage of inpatient hospital care to a reasonable number of days needed to permit appropriate placement of the client. An intensive rehabilitation program under these circumstances is not considered reasonable and necessary to the treatment of the client's illness or injury.

21-003.03B Further Progress is Unlikely: Rehabilitation services are covered until further progress toward the established rehabilitation goal is unlikely, or further progress may be achieved in a less intensive setting. In making decisions as to whether further progress may be carried out in a less intensive setting, the Department considers:
   1. The degree of improvement which has occurred; and
   2. The type of program required to achieve further improvement.

When further progress is unlikely, coverage is provided through the time it is reasonable for the physician, in consultation with the rehabilitation team, to have concluded that further improvement would not occur, and effected the client's discharge. Because planning is an integral part of any rehabilitation program and must begin upon the client's admittance to the facility, an extended period of time for discharge action is not reasonable after:
   1. Established goals have been reached;
   2. A determination has been made that further progress is unlikely; or
   3. Care in less intensive setting is appropriate.

21-004 Billing and Payment for Chiropractic Services

21-004.01 Billing

21-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 21, the billing requirements in 471 NAC Chapter 21 shall govern.

21-004.01B Specific Billing Requirements

   21-004.01B1 Billing Instructions: The provider shall bill Medicaid in accordance with the billing instructions included in this Chapter.
21-004.02 Payment

21-004.02A General Payment Requirements: Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 21, the payment regulations in 471 NAC Chapter 21 shall govern.

21-004.02B Specific Payment Requirements

21-004.02B1 Payment for Inpatient Care: All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem rate will be the sum of the following:

1. The hospital-specific base payment per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.1);
2. The hospital-specific capital per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.2); and
3. If applicable, the hospital's direct medical education per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.3).

Payment for each discharge equals the per diem rate times the number of approved patient days. Payment is made for the day of admission but not for the day of discharge.

21-004.02B2 Payment for Outpatient Hospital and Emergency Room Services: See 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services.

21-005 Evaluation Report and Plan of Care: The hospital shall submit an evaluation report to the Medical Director of the Division of Medicaid and Long-Term Care, or the Medicaid designated contractor, by the end of the second week following admission. The evaluation report must outline a detailed plan of care, and identify time frames applicable to each goal included in the rehabilitation program. The plan of care must contain a detailed staff report describing the client's:

1. Progress;
2. Problems; and
3. Discharge planning, involving possible relocation of the client to the most appropriate setting.
CHAPTER 22-000  RESPIRATORY THERAPY SERVICES

22-001  Definition:  Respiratory therapy (Respiratory Care) is defined as those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. Respiratory therapy services include, but are not limited to -

1.  The application of techniques for support of oxygenation and ventilation in the acutely ill patient. These techniques include, but are not limited to -
   a.  Establishment and maintenance of artificial airways;
   b.  Ventilator therapy and other means of airway pressure manipulation;
   c.  Precise delivery of oxygen concentration; and
   d.  Techniques to aid removal of secretions from the pulmonary tree.
2.  The therapeutic use and monitoring of medical gases (especially oxygen), bland and pharmacologically active mists and aerosols and equipment as resuscitators and ventilators;
3.  Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotracheal suctioning;
4.  Diagnostic tests for evaluation by a physician, such as pulmonary function tests, spirometry, and blood gas analyses;
5.  Pulmonary rehabilitation techniques which include -
   a.  Exercise conditioning;
   b.  Breathing retraining; and
   c.  Patient education regarding the management of the patient’s respiratory problems; and
6.  Periodic assessment and monitoring of the acute and chronically ill patients for indications for, and the effectiveness of, respiratory therapy services. Respiratory therapy services are performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel. If the services are reasonable and necessary, they are covered regardless of where in the hospital they are provided, such as emergency room, ICU, etc.

22-002  Covered Services:  To qualify for reimbursement as respiratory therapy under the Nebraska Medical Assistance Program, the therapy must -

1.  Qualify as a covered service (see 471 NAC 22-002.01);
2.  Be reasonable and necessary for the diagnosis or treatment of an illness or injury (see 471 NAC 22-002.02);
3. Be provided by or under the direct supervision of a respiratory therapist licensed by the Nebraska Department of Health and Human Services Regulation and Licensure, or, if provided out of state, similarly recognized by the respiratory therapy association or licensing entity of that state;

4. Be provided only on written orders by a licensed Nebraska physician, or, if provided out of state, a licensed physician of that state;

5. Be recertified by the physician every 30 days, or more frequently if the patient's condition necessitates; and

6. Be provided in a hospital or nursing facility.

22-002.01 Qualification as a Covered Service: NMAP covers respiratory therapy in the following circumstances:

1. Hospital: When provided by a respiratory therapist or technician, the services are covered as ancillary services. When provided by a nurse, the services are nursing services; and

2. Long Term Care Facilities: See 471 NAC 12-011.04C, Ancillary Services.

22-002.02 Reasonable and Necessary: To be considered reasonable and necessary for the diagnosis or treatment of an individual's illness or injury, respiratory therapy services furnished to a client must be:

1. Consistent with the nature and severity of the client's complaints and diagnosis;

2. Reasonable in terms of modality, amount, frequency, and duration of the treatments; and

3. Generally accepted by the professional medical community as being safe and effective treatment for the purpose used. These criteria are explained in the following parts.

22-002.02A Consistent with the Nature and Severity of the Individual's Complaints and Diagnosis: A patient's primary diagnosis alone may justify the need for respiratory therapy, such as myocardial infarction. There may be cases in which the primary diagnosis alone does not justify the need for respiratory therapy, but medical evidence indicates that the combination of the secondary and primary diagnoses might. There may also be cases in which the documentation indicates that the secondary diagnosis is of a severity that it alone justifies a need for respiratory therapy. Example: A patient who is admitted to the hospital with a secondary diagnosis of chronic obstructive pulmonary disease of a severity that the patient needed and used respiratory equipment before being admitted to the hospital, is considered to require respiratory therapy for that condition during the hospital stay.
22-002.02B Reasonable in Terms of Modality, Amount, Frequency, and Duration of the Treatments: Although respiratory therapy may be considered reasonable and necessary in a particular case based on the nature and severity of the patient's condition, it must also be reasonable and necessary with respect to modality, amount, frequency, and duration of the treatments.

Example: While a patient may require a particular type of modality to accomplish a certain therapeutic objective, the reasonableness and medical necessity may be questionable where more than one type of modality is used at the same time to accomplish the same therapeutic objective, such as IPPB and incentive spirometry.

In most circumstances, the need for therapy decreases with improvement of the condition, or increases if the condition worsens. In most instances, respiratory therapy is not considered reasonable and necessary when provided in the same amount and/or frequency throughout the client's hospital stay. It is expected that the level and intensity of the care is modified as discharge nears. If the amount and frequency of respiratory therapy provided throughout the hospital stay remains constant and the primary or secondary diagnosis indicates that, under normal circumstances, a decline in amount and frequency could be anticipated, the provider shall submit an explanation to the Department.

22-002.02C Generally Accepted by the Professional Community as Being Safe and Effective Treatment for the Purpose Used: In the absence of evidence to the contrary, it may be presumed that respiratory therapy is an accepted treatment and may be covered under the Nebraska Medical Assistance Program.

22-002.03 Additional Guidelines for Coverage Criteria: While there are many conditions for which respiratory therapy may be indicated, NMAP does not cover respiratory therapy services when performed on a mass basis with no distinction made as to the individual patient's actual condition and need for services. In addition, NMAP makes a distinction between respiratory therapy services and routine nursing services. The following parts illustrate some examples of the application of the coverage criteria.

22-002.03A Intensive Care and Recovery Room Patients: Intensive care and recovery room patients may require respiratory monitoring, support, and therapy. These respiratory care services (including equipment and maintenance thereof) qualify for reimbursement when reasonable and necessary. Frequency, intensity, and duration of monitoring and maintenance services will vary with the patient's illness, age, and underlying state of health.
22-002.03B Preoperative Bronchial Hygiene Therapy: NMAP does not consider bronchial hygiene therapy provided on a routine basis to preoperative patients to be reasonable and necessary and does not cover these services. Circumstances under which preoperative bronchial hygiene therapy may be reasonable and necessary include those situations when it is provided to patients with acute or chronic pulmonary disease which by itself requires respiratory therapy. In the absence of a presumptive condition, preoperative respiratory therapy could be reasonable and necessary if the prescribing physician adequately documents the medical necessity for it, for example, heavy smokers with chronic cough and sputum production. In these cases, the medical necessity for respiratory therapy is established if the documentation submitted adequately supports the therapy. A statement that respiratory therapy "is needed" or "is necessary based on diagnosis" is unacceptable.

22-002.03C Postoperative Bronchial Hygiene Therapy: Routine procedures such as deep breathing and cough instruction, frequent repositioning, and early ambulation provide for adequate bronchial hygiene in the majority of postoperative patients. Bronchial hygiene therapy services, in addition to those cited above when provided on a routine basis to most postoperative patients is not considered necessary and is not covered under NMAP.

Respiratory therapy services aiding bronchial hygiene, such as, IPPB, aerosol therapy, postural drainage, chest percussion and vibration, and nasotracheal suctioning, may be reasonable and necessary in the postoperative patient with identifiable pulmonary complications or in patients with underlying pulmonary diseases. In addition, the therapy may be required for several postoperative days for those patients. In these cases, the Medicaid provider must document the medical necessity for the therapy when billing the Department. It is reasonable to expect changes in modalities and decreases in frequency of therapy if pulmonary complications are not medically evident after several days of therapy postoperatively. Since the need for postoperative bronchial hygiene therapy cannot be identified presumptively, all therapy must be adequately documented by the physician.

22-002.03D Setting Up Equipment and Instructing Patients in Its Use: When appropriate, setting up respiratory equipment and instructing patients in the use of equipment or on postural drainage and breathing exercises are considered reasonable and necessary services. Once patients have been instructed in the use of the equipment or carrying out the postural drainage and breathing exercises themselves, services of a respiratory therapist or nurse are not reasonable and necessary, and are not covered by the Department. Any monitoring of the equipment or of the effects of the treatment is expected to be carried out by a staff nurse as part of his/her regular nursing activities. Use of a respiratory therapist for these activities is considered a duplication of services and is not covered. Payment may be made for use of the equipment and covered gases or drugs used in connection with the equipment.
22-002.03E Oxygen Therapy: Oxygen therapy is administered utilizing many devices ranging from the simple nasal cannula to progressively complex techniques providing controlled oxygen concentrations. These devices are usually applied, maintained, and monitored by respiratory therapists and technicians. These services are covered if the need and the effectiveness is documented.

The goal of oxygen therapy is to maintain adequate tissue and cell oxygenation while trying to minimize the danger of oxygen toxicity. Periodic measurement of the arterial PO$_2$ or oxygen saturation at rest and/or during exercise aids in determining the appropriate amount of oxygen to be administered, and is necessary until the client has achieved a stable status.

If the Department notes the use of continuous oxygen without periodic assessment of arterial PO$_2$ or oxygen saturation, it will request additional documentation to determine the medical necessity for the service. The physician's order must state the oxygen device and/or the specific flow rate or concentration of oxygen desired. A prescription for "oxygen as needed" does not meet these requirements. An intermittent or PRN oxygen therapy order must include time limits and specific indications for initiating and terminating therapy.

22-002.04 Structured Patient Education Program: While instructing a patient on the use of equipment, breathing exercises, etc., is considered reasonable and necessary to the treatment of the patient's condition, unless these activities are of a complexity that warrants a structured patient education program, the instructions can usually be given a patient during the course of his/her treatment by any of the health personnel involved such as the physician, nurse, or respiratory therapist. The patient activities involved in the management of respiratory problems are not ordinarily of the complexity that warrant a structured program. A structured program generally is not considered reasonable and necessary and is not covered by NMAP. Structured patient education programs which provide information over and beyond that ordinarily provided during the course of a treatment, such as extensive theoretical background in the pathology, etiology, and physiological effects of the disease, are not considered reasonable and necessary to the management and treatment of illnesses under NMAP.

22-003 Documentation: Respiratory therapy services may be subjected to pre-and/or postpayment utilization review. To help determine medical necessity for the treatments provided by the therapist, the following documentation must accompany each outpatient hospital claim:

1. A copy of the respiratory therapist's progress notes and anticipated goals; and
2. Information on the claim or as an attachment which includes -
   a. The location where the services were provided;
   b. The date of onset of the patient's condition; and
   c. The patient's diagnosis.

Each case is considered on its own merits. The Medicaid Division shall make the final determination, based upon the submitted documentation and whether the therapy is reasonable and necessary. The Department reimburses only for medically necessary therapy (see 471 NAC 22-002.02 and 22-002.03).

Any claim denied by Medicare for Medicare/Medicaid-eligible individuals will also be denied by the Department.

22-004 Payment for Respiratory Therapy Services: NMAP limits payment for respiratory therapy services to services provided in a hospital to a hospital patient or in a nursing home to a nursing home resident. NMAP does not reimburse the respiratory therapist directly; payment is made to the hospital or nursing home. Under certain extreme conditions, when medical necessity is documented, the Department may make exceptions to this policy. Prior authorization by the Medicaid Division is required.

For reimbursement as a hospital service, see 471 NAC 10-010, Payment for Hospital Services.

For reimbursement as a service in a nursing home, see 471 NAC 12-011, Rates for Nursing Facility Services.

22-005 Billing Requirements

   22-005.01 Procedure Codes: The provider shall use the appropriate American Medical Association’s Current Procedural Terminology (CPT) or HCPCS procedure codes when billing the Department.

   22-005.02 Medicare or Other Insurance Coverage: If the client is eligible for Medicare or has other insurance which may cover respiratory therapy, the provider shall bill the Medicare carrier or the insurance company before submitting a bill to the Department.

   22-005.03 Required Claims: Depending on the place of service, the provider shall use the claims required by the Department as follows:

   1. If the service is provided in a hospital, the hospital makes payment to the respiratory therapist. The hospital submits claims to the Department for respiratory therapy services provided in the hospital to inpatients and outpatients on Form CMS-1450 or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837); or

   2. If the service is provided in a long term care facility, the facility shall contract for services not readily available in the facility. Depending on the type of provider, reimbursement is claimed as follows:
a. If services are provided by another licensed facility (hospital or rehabilitation agency), the long term care facility makes payment to the provider. The long term care facility is reimbursed for the payment as an allowable cost under the long term care reimbursement plan; or

b. If services are provided by a facility staff member or by an individual under contract to the facility, the long term care facility makes payment to the individual. The facility is reimbursed under the long term care reimbursement plan.

22-005.04 Interval of Billing: To keep payment current, providers may submit claims to the Department on a monthly basis.
CHAPTER 23-000 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES

23-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), a qualified professional speech pathologist or a qualified professional audiologist must be licensed by the Nebraska Department of Health and Human Services. If services are provided outside Nebraska, the speech pathologist or audiologist must:

1. Have been granted a certificate of competency by the American Speech, Language, and Hearing Association;
2. Meet the equivalent educational and work experience requirements needed for a certificate of competency;
3. Have completed the academic program requirements and be acquiring the supervised work experience needed for the certificate of competency; or
4. Where applicable, licensed by the state.

23-001.01 Registered Communication Assistants: NMAP does not enroll registered communication assistants as providers. Services provided by a registered communication assistant are billable to NMAP when all requirements of 172 NAC 23 and 172 NAC 24 are met.

23-001.02 Provider Agreement: The speech pathologist of audiologist must complete and sign Form MC-19, “Medical Assistance Provider Agreement,” (see 471-000-90) and submit it to the Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care, to be approved for provider enrollment.

Out of state providers who are not licensed must submit a photocopy of the certificate of clinical competency to the Department with the signed and completed Form MC-19. Out-of-state individuals who meet the academic requirements but are acquiring work experience for certification must submit a signed and completed Form MC-19 to the Department to be approved for provider enrollment. The Department will submit Form MC-19, completed by the applicant-provider, to the Nebraska Speech Pathology and Audiology Licensure Board for evaluation.

23-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

23-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider must provide services only under arrangement with the HMO.

23-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. The client's primary care physician (PCP) in the PCCM must refer the client for speech therapy or audiology services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.
23-003 Covered Services: NMAP covers speech pathology and audiology services when the following criteria are met:

1. The services are ordered by a licensed physician;
2. The services are medically necessary;
3. The services are of such a level of complexity and sophistication or the condition of the patient is such that only a licensed speech pathologist or audiologist can safely and effectively perform the service; and
4. The speech pathology or audiology service meets at least one of the conditions listed in 471 NAC 23-003.01 or 23-003-02.

23-003.01 Services for Individuals Age 21 and Older: NMAP covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy and speech therapy). The service must be:

1. An evaluation; or
2. Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time; or
3. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

23-003-02 Services for Individuals Age 20 and Younger: NMAP covers speech pathology and audiology services for individuals birth to age 20 when the following criteria are met. The service must be:

1. An evaluation; or
2. Reasonable and medically necessary for the treatment of the client’s illness or injury; or
3. Restorative therapy with a medically appropriate expectation that the client’s condition; or
4. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.
23-003.03 Maintenance Therapy: NMAP does not cover maintenance therapy provided by a speech pathologist. The speech pathologist must:

1. Evaluate the client's needs;
2. Design a maintenance program;
3. Instruct the client, family members, or nursing facility staff in carrying out the program.

23-004 Non-Covered Speech Pathology and Audiology Services: NMAP does not cover, speech pathology or audiology services in the following situations:

1. Clients Age 21 and Older – therapy sessions in excess of 60 sessions per fiscal year for any combination of physical therapy, occupational therapy, and speech therapy;
2. Therapy for vocational and prevocational assessment and training;
3. Therapy for functional capacity evaluations, educational testing, drivers training, or training in non-essential self-help or recreational activities (e.g. homemaking, cooking, finance), visual perception training, or treatment of psychological conditions;
4. Therapy for dysfunctions that are self-correcting, such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting;
5. Therapy for delays in speech development that is not due to a specific disease or brain injury; or
6. Therapy for the following conditions or diagnosis categories:
   a. Psychosocial speech delay
   b. Behavior problems
   c. Attention disorders
   d. Conceptual handicap
   e. Learning disability
23-005 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of “Treatment Services” in 471 NAC 33-001.04. These services must be prior authorized by the Division of Medicaid and Long-Term Care.

23-006 Payment for Speech Pathology and Audiology Services

23-006.01 Payment for Individual Providers: NMAP pays for covered speech pathology and audiology services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Division of Medicaid and Long-Term Care (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

23-006.01A Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Division of Medicaid and Long-Term Care determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

23-006.02 Hospitals: For payment as a hospital service, see 471 NAC 10-000, Hospital Services.

23-006.03 Home Health Agencies: For payment as a home health agency service, see 471 NAC 9-000, Home Health Agency Services.
23-007 Billing Requirements

23-007.01 Medicare or Other Insurance Coverage: If a client is eligible for Medicare or has other insurance which may cover speech pathology or audiology services, the provider must bill the Medicare carrier or the insurance company before submitting a claim to the Department.

23-007.02 Medical Necessity Documentation: The provider must provide the following information when submitting a claim for speech pathology services:

1. Date of illness/injury onset;
2. Date speech pathology plan established;
3. Date speech pathology started; and
4. Number of speech pathology visits from onset.

23-007.03 Utilization Review: Claims for speech pathology and audiology services are subject to utilization review by the Department to determine medical necessity and appropriateness of service.

23-007.04 Required Forms and Standard Electronic Transactions: Depending on the place of service, the provider must use the forms and transactions required by the Department as follows:

1. If the service is provided at the patient's home or the provider's office, the provider must claim payment on Form CMS-1500 (see 471-000-61) or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837). The provider must use the appropriate place of service code and CPT or HCPCS codes on Form-CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837);
2. If the service is provided in a hospital, the hospital makes payment to the physical therapist. The hospital submits claims to the Department for physical therapy services provided in the hospital facility to inpatients or outpatients on Form CMS-1450 or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837); and
3. If the service is provided by a home health agency, the agency must claim payment on Form CMS-1450, (see 471-000-57) or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837).

The provider or the provider's authorized agent must enter the provider's usual and customary charge for each procedure code listed on or in the claim.
23-007.05 Procedure Codes: Individual providers billing on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) must use the American Medical Association’s Current Procedural Terminology (CPT) or HCPCS procedure codes when billing the Department. When billing on Form CMS-1500 with CPT procedure codes, NMAP defines 30 minutes of speech pathology services as "1" "unit of service".

Hospital providers billing on the appropriate institutional claim (see Claim Submission Table at 471-000-49) must use the appropriate revenue codes when billing the Department.

Home health providers billing on the appropriate institutional claim (see Claim Submission Table at 471-000-49) must use the procedure codes listed in 471-000-57.
CHAPTER 24-000 VISUAL CARE SERVICES

24-001 Definitions

Eyeglasses: A set of both lenses and a frame, used to correct deficiencies in vision.

Simple Photophobia: A photophobia condition which is not caused by a disease or other significant health issue. Also referred to as a sensitivity.

24-002 Provider Requirements

24-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of visual care services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 24, the participation requirements in 471 NAC Chapter 24 shall govern.

24-002.02 Service Specific Provider Requirements: To participate in Medicaid, providers of visual care services shall:
   i. Be enrolled in Nebraska Medicaid by complying with the provider agreement requirements included in 471 NAC 24-002.02A;
   ii. Be licensed to practice by the Nebraska Department of Health and Human Services, or if the service is provided in another state, by the other state;
   iii. Practice within their scope of practice as defined in Neb. Rev. Stat. Sections 38-2601 to 38-2623, or if the service is provided in another state, within the scope of practice as defined by the licensing laws of the other state;
   iv. Comply with all applicable state and federal laws and regulations governing the provision of their services.

24-002.02A Provider Agreement: Providers of visual care services shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

24-002.02B Contact Lens Services: Only providers whose licensure allows prescription, fitting, and supervision of adaptation, will be approved for payment of contact lenses.

24-003 Service Requirements

24-003.01 General Requirements

24-003.01A Medical Necessity: Vision services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A.
24-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

24-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

24-003.02 Covered Services: Medicaid covers medically necessary and appropriate visual care services within program guidelines.

24-003.02A Examination, Diagnostic, and Treatment Services: Medicaid covers eye examinations, diagnostic services, and other treatment services within program guidelines when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.

24-003.02A1 Eye Examinations

24-003.02A1a Clients Age 20 and Younger: Medicaid covers eye examinations for clients age 20 and younger once every 12 months, to the day. More frequent exams will be covered if medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.

24-003.02A1b Clients Age 21 and Older: Medicaid covers eye examinations for clients age 21 and older once every 24 months, to the day. More frequent eye examinations will be covered when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.

24-003.02A2 Vision Therapy: Medicaid covers vision therapy (orthoptics) when medically necessary and reasonable. Vision therapy is limited to a maximum of 22 sessions.

24-003.02B Frames: Medicaid covers one pair of eyeglass frames every 24 months, to the day, when either of the two following conditions is met:

i. Required for one of the following medical reasons –
   a. The client’s first pair of prescription eyeglasses;
   b. Size change needed due to growth; or
   c. A prescribed lens change, only if new lenses cannot be accommodated by the current frame.

ii. The client’s current frame is no longer useable due to irreparable wear/damage, breakage, or loss.

24-003.02B1 Clients Age 20 and Younger: For clients age 20 and younger, Medicaid covers frames more frequently if medically necessary and appropriate.

24-003.02B2 Frame Specifications: The following specifications apply to all eyeglass frames:

a. Plastic and metal frames are covered; rimless frames are not covered;

b. Discontinued frames with new prescription lenses are not covered; and

c. Frame cases are covered with new eyeglasses.
24-003.02B3 Billing Clients for Frames: Clients may choose to purchase their own frames on a private pay basis. Charges to clients for a frames purchased privately must include the associated fitting charge.

24-003.02B4 Frame Repair: Medicaid covers frame repair if less costly than providing a new frame and if the repair would provide a serviceable frame for the client. Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.

24-003.02B5 Frame Replacement: Replacement of frames which are irreparable due to wear/damage, breakage or loss, is limited to once per 12-month period, for clients age 21 years and older.

24-003.02C Lenses: Medicaid covers one pair of eyeglass lenses every 24 months, to the day, when either of the two following conditions is met:

i. Required for the following medical reasons –
   a. The client’s first pair of prescription eyeglasses;
   b. Size change needed due to growth; or
   c. New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):
      1. A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
      2. A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or
      3. A change of prism correction of ½ prism diopter vertically or 2 prism diopeters horizontally or more.

ii. The client’s current lenses are no longer usable due to damage, breakage, or loss.

When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.

24-003.02C1 Clients Age 20 and Younger: For clients age 20 and younger, Medicaid covers lenses more frequently if medically necessary and appropriate.

24-003.02C2 Specifications for Lenses: The following specifications apply to all eyeglass lenses -

a. Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian;

b. Lenses may be plastic or glass. For special lens material, see 471 NAC 24-003.02C3;

c. All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must indicate that the scratch resistant coating was provided Medicaid does not require that lenses with scratch resistant coating be warranted;
d. Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and

e. All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.

24-003.02C3 Special Lens Features and Lab Procedures: Medicaid coverage limitations are as follows;

a. Anti-reflective and mirror lens coating - not covered.

b. Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.

c. Blended and progressive multifocal lenses - not covered.

d. Drilling, notching, grooving, faceting of lenses - not covered.

e. Edging or beveling of lenses for cosmetic reasons - not covered.

f. Engraving - not covered.

g. High index lenses - covered only if the refraction correction is at least +/- 10.00 diopters in meridian of greatest power when placed on an optical cross.

h. Myodisc lenses - covered only if prescribed.

i. Nylon cord, metal cord, or rimless mount - covered only if the client purchases own frame or uses previously purchased frame.

j. Oversize lens charges - covered only if:

   i. Medically necessary (e.g., narrow interpupillary distance or unusual facial configuration); or

   ii. The client purchases his/her own frame or uses previously purchased frame.

k. Photochromatic and transition tints - not covered.

l. Polycarbonate (standard) lenses - covered for children. For adults, covered only if prescribed for clients with significantly monocular vision (e.g., due to amblyopia, eye injury, eye disease, or other disorder).

m. Polycarbonate (thin) lenses - covered for clients age 20 and younger. For clients age 21 and older, covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross.

n. Roll and polish edges - not covered.

o. Scratch resistant coating - see 471 NAC 24-003.02C2c for lens coating requirements. Additional scratch resistant coating is not covered.

p. Slab-off prism - covered only if there is at least 3.00 diopters of anisometropia in the vertical meridian.

q. Special base curve - covered only if prescribed for aniseikonia.

r. Tint - covered only for chronic disorders which cause significant photophobia under indoor lighting conditions. Simple "photophobia" is not an accepted diagnosis for coverage. Photochromatic tints and sunglasses are not covered.

s. Ultraviolet (UV) lens coating - covered only for chronic disorders that are complicated or accelerated by ultraviolet light.
24-003.02C4 Billing the Client for Lenses: The provider may bill the client for non-covered lens tints under the following conditions:
a. The client has been notified by the provider in writing that Medicaid will not cover the lens tint; and
b. The client voluntarily agrees to reimburse the provider for the lens tint on a private pay basis.

Providers are expressly prohibited from billing Medicaid for lenses that are not provided to the client. If non-covered lens features or lab procedures other than non-covered tints are desired by clients, they must purchase their own lenses on a private pay basis. The charge for lenses furnished on a private pay basis must include the associated portion of the fitting charge.

24-003.02C5 Lens Replacement: Replacement of lenses which are irreparable due to wear/damage, breakage or loss, is limited to once per lens in 12 month period, for clients age 21 years and older.

24-003.02D Eyeglass Fitting: Medicaid covers fitting of eyeglasses associated with provision Medicaid covered lenses and/or frames to a Medicaid client. Fitting includes:
1. Measurement of anatomical facial characteristics;
2. Writing of laboratory specifications;
3. Ordering eyeglasses;
4. Verifying order once received;
5. Final adjustment of the eyeglasses to the visual axes and anatomical topography;
6. Dispensing; and,
7. Any associated overhead (including shipping and postage charges).

24-003.02E Contact Lens Services: Contact lens services include prescription, fitting, supervision of adaptation, and supply of contact lenses. Medicaid covers contact lens services only when prescribed for clients with:
i. Keratoconus;
ii. Aphakia (excluding pseudophakia);
iii. High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction;
iv. High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction;
v. Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision; or
vi. Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.

24-003.02E1 Replacement of Contact Lenses: Covered when required due to loss, damage or for prescription changes when the client's condition meets the criteria for Medicaid coverage as outlined in 471 NAC 24-003.02E(i)-(vi) directly above.
24-003.03 Non-Covered Services: The following services are not covered by Medicaid:

24-003.03A Eyeglasses:
1. Sunglasses;
2. Multiple pairs of eyeglasses for the same individual;
3. Non-spectacle mounted aids, hand-held or single lens spectacle mounted low vision aids, and telescopic and other compound lens systems (including distance vision telescopic, near vision telescopes and compound microscopic lens systems); and
4. Replacement insurance.

24-003.03B Contact Lenses:
1. Medicaid does not cover contact lenses when prescribed for routine correction of vision.
2. Medicaid does not cover disposable contact lenses.

24-004 Billing and Payment for Visual Care Services

24-004.01 Billing

24-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 24, the billing requirements in 471 NAC Chapter 24 shall govern.

24-004.01B Specific Billing Requirements

24-004.01B1 Billing Requirements: Providers shall bill Medicaid for visual care services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49), and in accordance with the Billing Instructions included in Appendix 471-000-65.

24-004.01B2 Usual and Customary Charge: The provider or the provider's authorized agent shall submit the provider's usual and customary charge for services rendered. The provider's total charge for services may not exceed the provider's usual and customary charge.

24-004.01B3 Non-Covered Items or Services: If the provider furnishes items (frames, lenses, etc.) or services not covered by Medicaid, on a private basis, the client must pay the full charge of the items or services. The provider is prohibited from billing Medicaid for any portion of the non-covered items or services.

24-004.02 Payment

24-004.02A General Payment Requirements: Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with
payment regulations outlined in this 471 NAC Chapter 24, the payment regulations in 471 NAC Chapter 24 shall govern.

24-004.02B  Specific Payment Requirements

24-004.02B1 Reimbursement: Medicaid pays for covered visual care services in an amount equal to the lesser of:
   a. The provider's submitted charge; and
   b. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-524) in effect on the date the service was rendered by the provider.

24-004.02B2 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471-000-70.

24-004.02B3 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.

24-004.02B4 Payment for Eye Exams: Eye examinations provided primarily for the purpose of prescribing, fitting, or changing eyeglasses for refractive errors are reimbursed at the Medicaid fee schedule allowable for intermediate level general ophthalmological services, as defined in the American Medical Association's Physicians' Current Procedural Terminology (CPT). Determination of the refractive state is reimbursed separately from examination services.

24-004.02B5 Vision Therapy Training: Payment for vision therapy training includes all equipment and supplies necessary for home use.
CHAPTER 25-000 SPECIAL EDUCATION SCHOOL-BASED SERVICES: This chapter provides for a statewide billing system for accessing federal Medicaid funds for special education services provided by school districts, as authorized by Neb. Rev. Stat. § 43-2511. To be eligible for Medicaid payment, services must be provided in accordance with all regulations and statutes relating to the provision of approved services and the licensure, certification, and registration of therapists, therapy/therapist assistants, and aides/paraprofessionals, including:

2. The Occupational Therapy Practice Act (Neb. Rev. Stat. §§ 71-6101 to 71-6123);
3. The Physical Therapy Practice Act (Neb. Rev. Stat. §§ 71-1,362 to 71-1,389);
5. Regulations for Certificate Endorsements, Title 92 Chapter 24 of the Nebraska Administrative Code (NAC);
6. Regulations and Standards for Special Education Programs, 92 NAC 51; and
7. Regulations for the Approval of Teacher Education Programs, 92 NAC 20.

25-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP/Medicaid), the “Pay-to Provider” must be a recognized public school district of the State of Nebraska and enrolled in accordance with 471 NAC 25-002. Each therapist, therapist assistant, or aide/paraprofessional providing Special Education School-Based Services must also meet the following criteria.

25-001.01 Occupational Therapist: An occupational therapist providing services in Nebraska must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure (HHS R&L) in accordance with all regulations and statutes relating to the licensure of occupational therapists.

25-001.01A Occupational Therapy Assistant: If services are provided by an occupational therapy assistant under the supervision of a licensed occupational therapist, the occupational therapy assistant must be licensed by HHS R&L in accordance with all regulations and statutes relating to the licensure of occupational therapy assistants.

25-001.02 Physical Therapist: A physical therapist providing services in Nebraska must be licensed by HHS R&L in accordance with all regulations and statutes relating to the licensure of physical therapists.

25-001.02A Physical Therapist Assistant: If services are provided by a physical therapist assistant under the supervision of a licensed physical therapist, the physical therapist assistant must be certified by HHS R&L in accordance with all regulations and statutes relating to the certification of physical therapist assistants.

25-001.03 Audiologist and Speech-Language Pathologist: An audiologist or speech-language pathologist providing services in Nebraska must be licensed by HHS R&L or certified by the Nebraska Department of Education in accordance with all regulations and statutes relating to the licensure or certification of audiologists and speech-language pathologists.
25-001.03A Communication Assistant/Audiology Assistant (AA)/Speech-Language Pathology Assistant (SLPA): If services are provided by a communication assistant/AA/SLPA under the supervision of a licensed audiologist or speech-language pathologist, the communication assistant/AA/SLPA must be registered by HHS R&L in accordance with all regulations and statutes relating to the registration of communication assistants/AA’s/SLPA’s.

25-001.04 Personal Assistance/Care Services Aide/Paraprofessional: A motor activity paraprofessional, speech language technician, (occupational, physical, or speech-language) therapy aide, or other paraprofessional providing therapy-related personal assistance services related to the above listed therapies not licensed, certified or registered as outlined above must provide services in accordance with the provisions of the “Regulations and Standards for Special Education Programs” in 92 NAC 51 and all regulations and statutes governing the discipline for which the aide/paraprofessional is functioning.

25-001.05 Therapists Providing Services in Another State: Consideration will be given for an occupational therapist, physical therapist, or audiologist/speech-language pathologist providing services in another state to a Nebraska resident child/student. The therapist must be in good standing with and duly licensed by the licensing agency of the state where services are provided. However, information required of any therapist must be included with that of each enrolled public school district (Pay-to Provider) as outlined in 471 NAC 25-002.

25-002 Provider Enrollment: To be enrolled for participation in the Nebraska Medical Assistance Program, a public school district must submit a signed and completed Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90) to be approved for provider enrollment by the Nebraska Department of Health and Human Services Finance and Support Claims Processing – Provider Enrollment Unit.

25-002.01 Service Rendering Provider: Completed Medical Assistance Provider Agreements must include the name, social security number, and license number of all licensed therapists (service rendering providers) who provide Special Education School-Based Services or who are responsible for the supervision of licensed, certified, or registered therapist assistants providing therapy services.

25-003 Definition of Covered Services: The Nebraska Medical Assistance Program (NMAP/Medicaid) covers Special Education School-Based Services under this chapter for individuals when services are provided in accordance with all regulations and statutes governing the provision of Special Education School-Based Services to resident children of the State of Nebraska and the following criteria are met.

25-003.01 Provision of Special Education School-Based Services: All Special Education School-Based Services covered under this chapter must be necessary to meet the unique needs of the child/student and family and recommended as:

1. A related service or supplementary aid/service (92 NAC 51-007.05B3) in an Individual Education Program (IEP); OR
2. An early intervention service (92 NAC 51-007.10B4) in an Individualized Family Service Plan (IFSP);

25-003.01A All occupational therapy, physical therapy, and audiology/speech-language pathology must be provided in accordance with all regulations and statutes governing the provision of occupational therapy, physical therapy, and audiology/speech-language pathology in force at the time each discipline (therapy) is provided. Additionally, each therapy must be:

1. Referred or prescribed by a physician, physician's assistant, or certified nurse practitioner. If services are referred or prescribed by a physician's assistant, corresponding claims must include the license number of the supervising physician to whom the referring/prescribing physician's assistant is assisting; and
2. Provided by or under the supervision of a licensed therapist as applicable according to all regulations and statutes governing the provision of the Special Education School-Based Services.

25-003.02 Personal Assistance/Care Services: Personal assistance/care services provided in conjunction with occupational therapy, physical therapy, and audiology/speech-language pathology outlined above but provided by a motor activity paraprofessional, (occupational, physical, or audiology/speech-language) therapy aide, speech language technician, personal assistant, or other paraprofessional, in addition to the applicable requirements listed above, must be provided "under the direction" of a licensed therapist meeting the requirements outlined in 471 NAC 25-001.01, 25-001.02, and 25-001.03 respectively for the therapy/discipline indicated. "Under the direction of" means a licensed therapist actively participated in the development and periodic reevaluation and/or review of procedures for screening, diagnosis, or corrective services for eligible students through the development of the:

1. Student Assistance Team (SAT);
2. Multidisciplinary Team (MDT);
3. Individual Education Program (IEP) or;
4. Individualized Family Service Plan (IFSP).

25-004 Billing Requirements: The public school district (Pay-to Provider) must bill for Special Education School-Based Services using the appropriate MIPS Claim Form. Separate claims must be submitted for each month for each type of service (OT, PT, or ST) provided for each client/student.

25-004.01 Service Rendering Provider: When services are provided by a licensed therapist or licensed therapy assistant, MIPS claims must include the Social Security Number (SSN) of the individual therapist (service rendering provider) assuming responsibility for the service(s) provided. When only personal assistance/care services are included in the claim, an SSN is not required.
25-005 Establishing Payment Rates: Reimbursement rates for Medicaid covered services provided to students in accordance with all regulations and statutes governing the provision of Special Education School-Based Services are established for each of the following:

1. Occupational Therapy Services;
2. Physical Therapy Services;
3. Speech and Language Therapy/Audiology Services; and
4. Personal Assistance/Care Services.

Rates for each of the above listed services are established as provided in the Nebraska State Medicaid Plan on the basis of the actual cost to public school districts in each of the following areas, respectively:

1. Omaha Public Schools (Douglas County School District #001); and
2. Lincoln Public Schools (Lancaster County School District #001); and
3. All other public school districts in Nebraska (average aggregate cost of each of the services listed above).

These rates are established based on the Department's review of costs that are consistent with efficiency, economy, and quality of care. The State's review and update of these rates will consider cost information related to therapists' salaries and benefits; support materials and supplies; travel; and indirect costs. The principles and standards for determining reasonable and adequate costs associated with the provision of services are outlined in the Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments".
26-000 AMBULATORY SURGICAL CENTER (ASC) SERVICES

26-001 Standards for Participation: NMAP covers facility services provided by ambulatory surgical centers in connection with certain surgical procedures. To participate in the Nebraska Medical Assistance Program, an ambulatory surgical center must:

1. Be certified as meeting the requirements for an ASC under Medicare;
2. Have an agreement with CMS under Medicare to participate as an ASC; and
3. Have an agreement with the Nebraska Department of Health and Human Services to participate in NMAP. NMAP covers ASC facility services for only the surgical procedures defined in 471 NAC 26-004. The ASC must accept the Department's payment for the facility services as payment in full for those services defined as ASC facility services in 471 NAC 26-002.

26-001.01 Definition of an ASC: An ASC is a distinct entity that operates exclusively to provide outpatient surgical services to patients. An ASC may be either:

1. Independent (not part of a provider of services or any other facility); or
2. Operated by a hospital (under the common ownership, licensure, or control of a hospital).

26-001.01A ASC's Operated by Hospitals: If an ASC is operated by a hospital, it may be covered under Medicare as an independent ASC or as a hospital-affiliated ambulatory surgical center (HAASC). The Department enrolls ASC's to participate in NMAP as they are enrolled to participate in Medicare. To be covered as a Medicare-participating ASC operated by a hospital, a facility must:

1. Elect to do so, and continued to be covered as an ASC unless CMS determines there is good cause to do otherwise;
2. Be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and
3. Meet all Medicare's requirements for independent ASC's.

Facilities operated by a hospital as Medicare-participating ASC's are paid according to 471 NAC 26-005. Other HAASC's are paid according to 471 NAC 10-010.06.

26-001.02 Provider Agreement: The provider must complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit it to the Department to be approved for provider enrollment.
26-002 Covered ASC Procedures: NMAP covers ASC facility services performed in connection with procedures on the list of covered ASC procedures in 471-000-409, state defined ASC Services code(s). These procedures are organized in several groups that refer to the facility payment amount available for each group. The ASC receives the same payment for each procedure within a particular group.

The list of covered ASC procedures indicates which procedures may be covered if performed in an ASC; NMAP does not require that these procedures must be performed in an ASC. The general rules regarding the medical necessity of a specific procedure for a specific client apply to ASC services as they do to all other services covered by NMAP.

26-003 Covered ASC Facility Services: ASC facility services are items and services provided by an ASC in connection with a covered surgical procedure defined in 471 NAC 26-002. These items and services are those that would otherwise be covered by NMAP if provided on an inpatient or outpatient basis in a hospital in connection with that surgical procedure.

The fee for ASC facility services includes payment for:

1. Nursing, technician, and related services;
2. Use of ASC facilities;
3. Drugs, biologicals, surgical dressings, splints, casts, and appliances and equipment directly related to the provision of a surgical procedure;
4. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
5. Administrative, record keeping, and housekeeping items and services;
6. Blood, blood plasma, platelets, etc.; and
7. Materials for anesthesia.

The fee for ASC facility services does not include payment for medical and other health services, such as physicians' services and prosthetic devices for which payment may be made under other NMAP payment plans, except for intraocular lenses. See 471 NAC 26-004, ASC Services Not Included in the ASC Facility Services Fee.

26-003.01 Nursing, Technician, and Related Services: The fee for ASC facility services includes payment for all services provided by nurses and technical personnel who are employees of the ASC in connection with covered procedures. In addition to nursing staff, this includes orderlies, technical personnel, and others involved in patient care.

26-003.02 Use of ASC Facilities: The fee for ASC facility services includes payment for operating and recovery rooms, patient preoperation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with covered procedures.
26-003.03 Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment: The fee for ASC facility services includes payment for all supplies and equipment commonly provided by the ASC in connection with covered procedures. Coverage of drugs and biologicals is limited to those which cannot be self-administered.

The following supplies and dressings are included in the ASC facility services fee:

1. Primary surgical dressings that are usually applied first by a physician in the ASC setting. These surgical dressings are therapeutic and protective coverings applied to lesions on the skin or openings to the skin required as a result of surgical procedures; and
2. Splints, casts, and other supplies, such as supplies required for the patient and ASC staff, that is, gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

26-003.04 Diagnostic or Therapeutic Services and Items: The fee for ASC facility services includes payment for items and services provided by ASC staff in connection with covered procedures. With respect to diagnostic tests, many ASC's perform simple tests just before surgery, primarily urinalysis and blood hemoglobin or hematocrit, which are generally included in their facility charges. To the extent that these simple tests are included in the ASC's facility charges, they are considered facility services. Under NMAP, diagnostic tests are not covered in laboratories independent of a physician's office, rural health clinic, or hospital unless the laboratory meets Medicare's requirements for independent laboratories; therefore, diagnostic tests performed by the ASC other than those generally included in the facility's charge are not included in the fee for ASC facility services. The ASC's laboratory may be certified as an independent lab by Medicare; in this case, the ASC may bill NMAP separately for the tests performed.

The ASC may make arrangements with an independent laboratory or other laboratory, such as a hospital laboratory, to perform diagnostic tests required before surgery; however, the necessary laboratory tests will generally have been done outside the ASC before surgery is scheduled because the tests results may determine whether the client's surgery should be performed on an outpatient basis.

26-003.05 Administrative, Record Keeping, and Housekeeping Items and Services: The fee for ASC facility services includes payment for the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, and rent.

26-003.06 Blood and Blood Products: The fee for ASC facility services includes payment for blood and blood products. No separate or additional payment is made for blood and blood products.
26-003.07 Materials for Anesthesia: The fee for ASC facility services include payment for the anesthetic and any materials, disposable or reusable, necessary for its administration.

26-004 ASC Services Not Included in the ASC Facility Services Fee: NMAP makes a single payment (the fee for ASC facility services) to an ASC which covers "facility services" provided by the ASC in connection with a covered procedure. The ASC may provide a number of items and services covered by NMAP which are not included in the fee for ASC facility services. The ASC may be part of a medical complex that includes other entities, such as an independent laboratory, a supplier of durable medical equipment, ambulance services, or a physician's office, which NMAP covers separately. Items or services which are not included in the fee for ASC facility services are:

1. Physicians' services;
2. The sale or rental of durable medical equipment for use in the patient's home;
3. Prosthetic devices, that is, artificial legs, arms, and eyes;
4. Ambulance services;
5. Orthotic devices, that is, leg, arm, back, and neck braces; and
6. Services provided by an independent laboratory. The ASC may provide these services and bill NMAP for them in addition to the fee for ASC facility services. Refer to the appropriate chapter in Title 471 for coverage conditions and payment policies.

26-004.01 Physicians' Services: This category includes most covered services provided in ASC's which are not considered ASC facility services. Physicians' services include services of anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patient's recovery from the anesthesia. Physicians' services also include any routine pre- and post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, and changing of dressings. See 471 NAC 18-004.17, Surgery, and 471 NAC 18-006, Payment for Physicians' Services.

26-004.02 Durable Medical Equipment: The following items are not included in the fee for ASC facility services; when provided by the ASC facility in connection with a covered procedure, the ASC may bill for these services in addition to the ASC facility services fee:

1. Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands, and which are generally used as secondary coverings;
2. Surgical dressings that are reapplied later by others, including the patient or a family member;
3. Recasting and resplinting, when provided on a date other than the date the surgical procedure was performed.

When these dressings and supplies are obtained by the patient on a physician's order from a supplier other than the ASC facility, they are covered under 471 NAC 7-000 ff.

26-004.03 Ambulance Services: Ambulance services are not included in the fee for ASC facility services. Ambulance services provided by the ASC are covered as ASC services only if provided in conjunction with a covered ASC procedure and only when any other form of transportation is contraindicated for the patient's condition. Licensure and other ambulance regulations are covered in 471 NAC 4-000.

26-004.04 Laboratory Services: Except for those laboratory services included in ASC facility services under 471 NAC 26-003.04, laboratory services are covered in 471 NAC 10-003.04 and 18-004.29.

26-005 Payment for ASC Services

26-005.01 Fee for ASC Facility Services: For services provided on or after January 1, 2008, NMAP will utilize the 2006 Medicare ambulatory surgical center group rates to reimburse for an ambulatory surgical center service. Reimbursement will be the surgical group rate specific to the procedure as established in 471-000-409.

If one covered ambulatory surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate. For example, excision of a benign lesion is a "group 1" procedure; therefore, NMAP would pay 100% of the "group 1" rate.

If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure. For example, hammertoe repair is a "group 4" procedure and tenotomy is a "group 1" procedure. Payment for these procedures performed in a single operative session in an ASC would be 100% of the "group 4" rate and 50% of the "group 1" rate.

26-005.02 (Reserved)
26-005.03 Payment for Services Not Included in the ASC Facility Services Fee: The fee for facility services does not include payment for physicians’ services or other services not directly related to the performance of the surgical procedure. (See 471 NAC 26-004.) The ASC may bill for these services in addition to the fee for ASC facility services and will be paid according to the appropriate Medicaid payment plan.

26-005.04 Payment for State-Defined Services: Medicaid may cover payment for facility services provided in connection with certain state-defined services provided in an ASC. See 471 NAC 18-004.17E.

26-005.05 Non-Payment of Other Provider Preventable Conditions (OPPCs): Effective on or after the effective date of this regulation for facility services rendered by an ambulatory surgical center, payment will be denied for the following OPPCs:

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

26-006 Billing Requirements

26-006.01 Required Forms: When billing Medicaid, the ASC must submit on the appropriate form or electronic format (see Claim Submission Table at 471-000-49).

All claims for ASC services must include the date of surgery and the physician's name and license number.

26-006.02 Procedure Codes: To claim the ASC facility fee, the ASC must use the appropriate HCPCS/CPT procedure codes as outlined in claim completion instructions (see 471-000-52) and see 471-000-409, state defined ASC Services code(s).

The ASC must use HCPCS/CPT procedure codes when billing for practitioner services and laboratory services. Regulations listed in 471 NAC 4-000 must be used for ambulance services. Regulations listed in 471 NAC 7-000 must be used for durable medical equipment and medical supplies.
27-000 NON-EMERGENCY TRANSPORTATION (NET) SERVICES

27-001 Service Definitions: the following words, terms and phrases when used in this section shall have the following meanings:

**Base Rates**: Non-emergency medical transportation base rates include all services, equipment and other costs, including: vehicle operating expenses, services of personnel, first five “Loaded” miles of the trip, unloaded mileage, and usual waiting/standby time.

**Department**: The Department of Health and Human Services (DHHS) as established by the Health and Human Services Act.

**Department staff**: Employees of the Department of Health and Human Services or designees assigned those responsibilities.

**Exempt Provider**: Transportation carriers exempted from Nebraska Public Service Commission certification as defined in Neb. Rev. Stat. §§ 75-303 to 75-303.03.

**Free Transportation**: An appropriate mode of transportation that can be secured by the client without cost or charge, including the client’s personal vehicle or through access to a vehicle in the household that is owned by a legally responsible individual for the client.

**Individual Provider**: An individual carrier who meets the requirements of Neb. Rev. Stat. § 75-303 (11), (12), or (13), has an approved service provider agreement with the Department and is chosen by the client.

**Legally Responsible Individual**: A parent or guardian of a minor child, or spouse.

**Loaded Mileage**: Miles traveled while the client is present in the vehicle. Loaded mileage is covered for non-emergency medical transports when travel exceeds six or more miles. The first five loaded miles are included in the payment for the base rate.
Mode: The method used to provide transportation services to clients. This includes personal vehicle owned by individual provider; fixed route public transportation; ambulatory sedan, van, handi-bus; wheelchair-accessible van; and commercial airlines.

Most Appropriate: The least costly mode of transportation to meet a client’s medical needs that accommodates the client based on the client’s physical, cognitive or developmental capabilities.

Nebraska Medicaid Coverable Services: A medical service that is covered by the Nebraska Medicaid Program as specified in Nebraska Administrative Code (NAC) Title 471 (see Appendix 471-000-200).

NET Broker: An entity under contract with DHHS, chosen through a competitive bidding process, to perform all administrative brokerage functions including, but not limited to establishing a transportation network; receiving NET service requests; verifying client program(s) eligibility; screening clients for mobility status and existing transportation resources; determining appropriateness and coverage of program services; approving and arranging for transport; notifying client of transportation arrangement; and facilitating provider payment for completed services.

NET Service Provider: NET services provided by an approved Individual, Exempt or PSC Provider.

Non-Emergency Transportation (NET) Service: Non-Emergency Transportation (NET) Services are a ride, or mileage reimbursement for a ride, and escort/attendant services provided so that a Medicaid eligible client with no other transportation resources can receive Medicaid coverable services. By definition, NET services do not include transportation provided on an emergency basis, such as trips to the emergency room.

No Show: A trip that is not cancelled where the client or NET provider does not arrive as scheduled; or a scheduled trip that is not cancelled prior to the service when either the client or the NET provider fails to arrive.

Public Service Commission (PSC) Certified Carrier: Transportation providers requiring Nebraska Public Service Commission certification as defined in Neb. Rev. Stat. § 75-302 including the following carriers:

Common Carrier means any person who or which undertakes to transport passengers or household goods for the general public in intrastate commerce by motor vehicle for hire, whether over regular or irregular routes, upon the highways of this state.
Contract Carrier means any motor carrier which transports passengers or household goods for hire other than as a common carrier designed to meet the distinct needs of each individual customer or a specifically designated class of customers without any limitation as to the number of customers it can serve within the class.

Unloaded Mileage: Miles traveled when a client is not present in the vehicle. All unloaded mileage is included in the payment for the base rate.

Urgent: A serious, but not life threatening, illness/injury. Urgent care is determined by the client’s medical care provider. An appointment shall be considered urgent if the medical service provider grants an appointment within 48 hours of the client’s request. An inpatient or outpatient hospital discharge shall be considered an Urgent Trip.

Wait time: Periods of time that a NET provider spends waiting for the client prior to or in between the provision of covered NET services.

27-002 Covered Services: Medicaid covers the most appropriate NET services necessary to obtain Nebraska Medicaid-coverable services (see 471 NAC 1-002 for a list of Nebraska Medicaid coverable services) when one of the following criteria is met:

1. Client does not own or does not have access to a working licensed vehicle;
2. Client does not have a current valid driver's license;
3. Client is unable to drive due to a documented physical, cognitive, or developmental limitation;
4. Client is unable to travel or wait by him/herself due to a documented physical, cognitive, or developmental limitation; or
5. Client is unable to secure free transportation as defined in this chapter.

27-002.01 NET Services Provided for Clients Residing in Nursing Facilities or ICF/DD’s when Medicaid is the Primary Insurance: NET services for nursing facility or ICF/DD residents may be covered under this chapter for facility discharge transportation to a private residence within boundaries of the state of Nebraska.

27-002.02 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: All transportation services for medically necessary EPSDT covered services will be provided without regard to service limitations defined within this chapter, and with prior authorization.
27-002.03 (Reserved)

27-002.04 Provider Location: NET services are available to the nearest Nebraska Medicaid coverable services within a 20-mile radius of the client’s residence, able to meet the client’s medical needs, and willing to accept the client as a patient, unless otherwise exempted or approved by the Department.

27-003 Non-Covered Services: The following NET services are not covered by Nebraska Medicaid:

1. Transportation to obtain services not coverable by Nebraska Medicaid;
2. Transportation for clients residing in nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF/DD), except circumstances outlined in 471 NAC 27-002.01;
3. Transportation of family members to visit a hospitalized or institutionalized member;
4. Transportation to a Durable Medical Equipment (DME) provider that provides a delivery service that can be accessed at no cost to the client, in addition to the delivery of DME products in lieu of transporting the client;
5. Transportation for Medicaid covered services provided in the client’s home such as personal care, home health, etc;
6. Transportation to a pharmacy that provides a delivery service that can be accessed at no delivery cost to the client, with the exception of a new prescription requiring immediate use not otherwise reasonably accessible to the client; in addition to the delivery of pharmacy products in lieu of transporting the client;
7. Transportation to a hospital emergency room;
8. Client-provided transportation utilizing his/her own personal vehicle;
9. Wait times;
10. Services provided by Department staff or a legally responsible individual for the client; and
11. No shows.

27-004 Authorization Procedures: Authorization for NET services shall be requested for a scheduled trip at least three business days in advance, with the exception of an unscheduled trip for urgent medical care as defined in this Chapter. The authorization shall be requested through the NET Brokerage, and the NET Brokerage shall arrange the trip(s) according to the most appropriate mode of transportation for the service provided to the client as specified in 471 NAC 27-002.
27-004.01 Minor Children: A minor child under age 13 may not be transported by a NET provider without adult supervision by a legally responsible individual or an adult designated by a legally responsible individual.

27-004.02 Additional Passengers: The transportation for one legally responsible adult, or an adult designated by a legally responsible adult, may be authorized to accompany a minor child under age 19 as an additional passenger.

The transportation for a Personal Assistance Services provider may be authorized to accompany a client as an additional passenger.

27-005 Payment for Services

27-005.01 Conditions for Payment: The provider may bill Medicaid only when:

1. The transportation is furnished by a Medicaid enrolled provider to whom a direct vendor payment can be made; and
2. The client is actually in the vehicle.

27-005.02 Upper Limits: The Department establishes the NET Service Fee Schedule according to the following limits:

27-005.02A PSC Certified Carriers: Neb. Rev. Stat. §75-303.02 limits the distance rates for common carriers at a rate not to exceed the rate of reimbursement pursuant to Neb. Rev. Stat. §81-1176 multiplied by three. The maximum reimbursement rate does not apply when the carrier transports the client wholly within the corporate limits of the city or village where the transportation of the client originated pursuant to §75-303.02.


27-006 Billing Requirements: For services billed to Medicaid, providers shall submit claims through the NET Brokerage.
27-007 Provider Participation: To participate in the Nebraska Medicaid Program, providers of NET services shall fully meet all applicable local, state, and federal laws and regulations governing the provision of their services.

27-007.01 Provider Agreement: The NET provider shall complete and sign the "Service Provider Agreement" with the "NET Service Provider Agreement Addendum" found on the Nebraska Medicaid Provider Enrollment website and submit for approval to participate in Medicaid. NET Service provider agreements are renewed annually to ensure the provider continues to meet all provider standards.

27-007.02 Provider Compliance Reviews: The NET provider agreements are reviewed annually to ensure the provider continues to meet all provider requirements for provider participation.

27-007.03 NET Service Provider Standards: A provider shall meet all requirements set forth in the NET Brokerage Provider Manual and not have been terminated as a provider for cause from any Department program within the last ten years;

27-007.04 NET Provider Vehicle Requirements: Providers shall meet all vehicle standards in accordance with the NET Brokerage Provider Manual.

27-007.05 Driver Qualifications: Providers shall ensure drivers:

1. Be age 19 or older;
2. Possess a current and valid driver’s license with no more than three points assessed against his/her Nebraska driver’s license within the past two years, or meet a comparable standard in the state in which s/he is licensed to drive;
3. Not had his/her driver/chauffeur’s license revoked within past three years;
27-008 Background Checks:

27-008.01 Nebraska Child Abuse and Neglect Central Register and Adult Protective Services Central Registry checks: Nebraska Child Abuse and Neglect Central Register and Adult Protective Services Central Registry checks shall be completed for each potential driver prior to providing services and annually thereafter. This shall include registry checks in the state of residence or previous residence, if the state provides this service, when the potential driver does not reside in Nebraska or has resided in Nebraska for less than one year.

A driver will not be approved if a report of abuse or neglect concerning the driver has been determined to be “Court Substantiated”, “Agency Substantiated”, or “Court Pending” on the Nebraska Child Abuse and Neglect Central Register or on the Adult Protective Services Central Registry.

27-008.02 Nebraska State Patrol Sex Offender Registry checks: A Nebraska State Patrol Sex Offender Registry check shall be completed for each potential driver prior to providing services and annually thereafter. This shall include a registry check in the state of residence or previous residence, if the state provides this service, when the potential driver does not reside in Nebraska or has resided in Nebraska for less than one year.

A driver will not be approved if their name appears on the Nebraska State Patrol Sex Offender Registry.

27-008.03 Criminal History Checks: Provider staff shall ensure criminal history checks are completed for each potential driver prior to providing services and annually thereafter.

1. Individual Providers: If the driver is an individual, the Department staff shall:
   a. Obtain a criminal history statement from the driver. This statement shall identify any record of any felony or misdemeanor convictions. This shall include details, dates, and disposition (e.g., parole, probation, incarceration, fine, community service, etc.); and
   b. Perform a Nebraska statewide criminal background check of the driver. The driver shall provide Department staff with a statewide criminal history check in the state of residence when the driver does not reside in Nebraska, or previous state(s) of residence, if the driver has resided in Nebraska for less than 15 years.
2. **PSC and Exempt Providers**: PSC certified carriers and exempt providers shall perform a nationwide criminal background check on all drivers, whether employees or independent contractors. Records shall be maintained by these carriers and providers, and shall be made available to Department staff upon request.

27-008.03A **Specific Criminal History**: Drivers shall not have a history of misdemeanor or felony conviction(s) in the State of Nebraska or any other state, that include crimes against a child or vulnerable adult; crimes involving intentional bodily harm; crimes involving the illegal use of a controlled substance; or crimes involving moral turpitude on the part of the potential driver. Examples include but are not limited to the following:

1. Child pornography;
2. Child or adult abuse;
3. Driving under the influence, pending charge or conviction within the past eight years;
4. Domestic assault;
5. Shoplifting after age 19 and within three years prior to the criminal history review;
6. Felony fraud within the last ten years;
7. Misdemeanor fraud within the last five years;
8. Possession of any controlled substance within the last five years;
9. Possession of a controlled substance with intent to deliver within the last five years;
10. Felony or misdemeanor assault without a weapon in the last ten years;
11. Felony or misdemeanor assault with a weapon in the last 15 years;
12. Prostitution or solicitation of prostitution within the last five years;
13. Felony or misdemeanor robbery or burglary within the last ten years;
14. Rape or sexual assault; or
15. Homicide.
Chapter 28-000 PRESUMPTIVE ELIGIBILITY

28-001 Presumptive Eligibility for Pregnant Women: Under Section 1920 of the Social Security Act, Medicaid covers ambulatory prenatal care provided by an enrolled Medicaid provider to a pregnant woman during a presumptive eligibility period determined by a qualified provider. A pregnant woman is eligible for only one presumptive eligibility period per pregnancy.

Ambulatory prenatal care is defined as ambulatory services related to the pregnancy excluding inpatient hospital services, nursing home services, labor and delivery services, and services furnished to deliver or remove an embryo/fetus from the mother or services following such a procedure.

28-001.01 Definition of a Qualified Provider: Only a qualified provider is allowed to make the presumptive eligibility determination. A qualified provider must meet the following four criteria:

1. Have a current provider agreement with Medicaid;
2. Provide services of the type provided by one of the following:
   a. An outpatient hospital;
   b. A rural health clinic; or
   c. A clinic under the direction of a physician, without regard to whether the clinic itself is administered by a physician;
3. Meet one of the following requirements:
   a. Receive funds under one of the following:
      (1) The Migrant Health Centers or Community Health Centers (Sections 329, 330, or 340, of the Public Health Service Act);
      (2) The Maternal and Child Health Services Block Grant Program (Title V of the Social Security Act); or
      (3) Title V of the Indian Health Care Improvement Act;
   b. Participate in a program established under one of the following:
      (1) The Special Supplemental Food Program for Women, Infants, and Children (Section 17 or the Child Nutrition Act of 1966); or
      (2) The Commodity Supplemental Food Program (Section 4(a) of the Agriculture and Consumer Protection Act of 1973);
   c. Participate in a State perinatal program; or
   d. Is itself the Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638); and
4. Have been specifically designated in writing by the Division of Medicaid and Long-Term Care as a qualified provider for the purposes of determining presumptive eligibility.

The provider shall immediately notify the Division of Medicaid and Long-Term Care in writing should they no longer meet the required criteria to be a qualified provider. The provider shall discontinue making presumptive eligibility determinations when the requirements for being a qualified provider are no longer met.
28-001.02 Provider Approval: A provider who meets the requirements of 471 NAC 28-001.01 may request approval as a qualified provider for presumptive eligibility determinations from the Medicaid Division. The provider shall submit a written request for approval as a qualified provider to the Administrator of the Medicaid Division. The written request must identify the requirements of 471 NAC 28-001.01 the provider meets as well as how the provider will check active or pending Medicaid status for potential presumptively eligible pregnant women. The Medicaid Division shall coordinate with the Economic Assistance Division and the local Department of Health and Human Services (DHHS) office for the training of the qualified provider. The provider must be trained by the Medicaid and Economic Assistance Division staff, or staff approved by the Medicaid and Economic Assistant Division, before approval as a qualified provider is given. Final approval of the trained qualified provider is made in writing by the Medicaid Division. The designation of a qualified provider may be terminated by the Medicaid Division upon written 30-day notice to the qualified provider.

28-001.03 Presumptive Eligibility Determination: A pregnant woman may apply at a qualified provider’s office (see 471 NAC 28-001.01) for ambulatory prenatal services. The provider makes a presumptive determination of the woman’s eligibility based only on declared income and citizenship/eligible alien status. Income of the woman and spouse (if he is in the home) is counted. Income of the responsible parent(s) of a pregnant minor is counted unless the pregnant woman is an emancipated minor. The provider does not investigate resources or other eligibility requirements. See 477 NAC 1-004 for definition of emancipated minor. For income levels, see 471-000-202.

28-001.04 Responsibilities of the Qualified Provider: The qualified provider shall complete the following actions during the process of making a presumptive eligibility determination:

1. Check for any current or pending Medicaid eligibility prior to completing a presumptive eligibility determination;
2. Check for any past presumptive eligibility period during the client’s current pregnancy. A pregnant woman may receive only one period of presumptive eligibility per pregnancy;
3. Inform the woman at the time the determination is made:
   a. The copy of the presumptive eligibility application is the client’s proof of coverage and is a Medicaid application;
   b. She is required to provide verification and documentation as requested by DHHS;
   c. Presumptive eligibility ends when DHHS makes a determination of eligibility for medical assistance or at the end of the 45-day presumptive period; and
4. Forward a copy of the presumptive eligibility application, along with the attestation form if applicable, to the local DHHS office within five working days after making a presumptive eligibility determination.

5. If the woman is not presumptively eligible, inform her in writing:
   a. Of the reason for her ineligibility; and
   b. That she may file an application for the Nebraska Medical Assistance Program (also known as medical assistance or Medicaid) at the local DHHS office.

6. A presumptive application approved in error will be closed by DHHS upon discovery.

28-001.05 Appeal Rights: The standard notice and appeal rights apply for a woman who has been denied continuous medical assistance (see 465 NAC 2-001). There are no appeal rights with regard to the denial of presumptive eligibility.

28-002 (Reserved)
28-003 Presumptive Eligibility for Women with Cancer: Under Section 1920B of the Social Security Act, the Nebraska Medical Assistance Program (NMAP) covers services provided by an enrolled NMAP provider to a woman during a presumptive eligibility period when the woman has been screened by the Every Woman Matters Program and found to have breast or cervical cancer. Presumptive eligibility must be determined by a qualified entity.

Beginning September 1, 2001, women determined presumptively eligible will be eligible for the full scope of services under the State Plan during the presumptive eligibility period. A woman may qualify for presumptive eligibility each time a qualified provider finds her to meet the presumptive eligibility requirements.

28-003.01 Definition of a Qualified Entity: Only a qualified entity is allowed to make the presumptive eligibility determination. A qualified provider must meet the following criteria:

1. Is eligible for payments under the Medicaid State Plan and provides items and services covered by the NMAP or is eligible for payments as an administrative contractor under the State Medicaid plan, and
2. Is determined to be capable for making presumptive eligibility determinations and has been specifically designated in writing by the Medicaid Division as a qualified entity for the purpose of determining presumptive eligibility in accordance with the requirements listed and any other limitations issued by the Center for Medicare and Medicaid Services (CMS).

The provider must immediately notify the Medicaid Division in writing should they no longer meet the required criteria to be a qualified provider. The provider shall discontinue making presumptive eligibility determinations when the requirements for being a qualified provider are no longer met.

28-003.02 Provider Approval: An entity who meets the requirements of 471 NAC 28-003.01 may request approval as a qualified entity for presumptive eligibility determinations from the Medicaid Division. The entity must submit a written request for approval as a qualified entity to the Administrator of the Medicaid Division. The written request must identify the requirements of 471 NAC 28-003.01 the provider meets as well as how the provider will check active or pending Medicaid status for potential presumptively eligible women with either breast or cervical cancer. The Medicaid Division shall coordinate with the Economic Assistance Division and the local Department of Health and Human Services (DHHS) office for the training of the qualified entity. The Medicaid Division makes final approval of the trained qualified entity in writing. The entity must be trained by the Medicaid and Economic Assistance Division staff, or staff approved by the Medicaid and Economic Assistance Division, before approval as a qualified entity is given. The Medicaid Division, upon written 30-day notice to the qualified provider, may terminate the designation of a qualified entity.
28-003.03 Presumptive Eligibility Determination: A woman in need of treatment for certain breast or cervical cancer conditions may apply for presumptive eligibility for Medicaid-covered services at a qualified provider’s site. The qualified entity shall make a presumptive eligibility determination based only on the eligibility requirements in 469 NAC 9-000 which state that a woman must:

1. Be screened for breast and cervical cancer by Every Woman Matters;
2. Be found to need treatment for breast and/or cervical cancer, including a precancerous condition or early stage cancer;
3. Be uninsured, not have creditable coverage or be covered by Medicaid;
4. Be a Nebraska Resident.

The qualified entity does not investigate resources or other eligibility requirements. The DHHS must determine eligibility for medical assistance within 45 days of the woman’s application for medical assistance.

28-003.04 Responsibilities of the Qualified Entity: During the process of making a presumptive eligibility determination the qualified entity must:

1. Check for any current or pending Medicaid eligibility prior to completing a presumptive eligibility determination;
2. Inform the woman at the time the determination is made that:
   a. The copy of the presumptive eligibility application is the client’s proof of coverage;
   b. She is required to follow through with the eligibility process by applying for Medicaid no later than the last day of the month following the month during which the presumptive eligibility determination is made.
   c. The presumptive eligibility ends when a final determination is made by DHHS or if the woman does not apply for Medicaid, the last day of the month following the month during which the entity makes the presumptive eligibility determination.
3. Forward a copy of the presumptive eligibility application to the DHHS office within five working days after making a presumptive eligibility determination.
4. If the woman is not presumptively eligible, inform her (or the individual acting on her behalf) in writing:
   a. Of the reason for ineligibility; and
   b. That she may file an application for medical assistance at the local DHHS office.

28-003.05 Appeal Rights: The standard notice and appeal rights apply for a woman who has been denied continuous medical assistance. There are no appeal rights with regard to the denial of presumptive eligibility.
29-000 FEDERALLY-QUALIFIED HEALTH CENTERS (FQHC’S)

29-001 Standards for Participation: To be considered a Federally-Qualified Health Center (FQHC) for the Nebraska Medical Assistance Program, as allowed by section 6404 of P.L. 101-239, a health center must furnish proof that the United States Public Health Service has determined that it is qualified under Sections 329, 330, or 340 of the Public Health Service Act, or that it qualifies by meeting other requirements established by the Secretary of the Federal Health and Human Services.

29-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

29-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;
2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and
3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed by the HMO, regardless of whether the service is provided by a PCP enrolled with the HMO or a family planning provider outside the HMO.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

29-002.02 Primary Care Case Management (PCCM) Plans: All NMAP regulations apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider must obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As define under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and
2. Abortions: As currently defined, abortions require prior authorization by NMAP.
29-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP must authorize the services to be provided by the approved provider as needed with the following exceptions:

1. **Visual Care Services**: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers must contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedures provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.

2. **Dental Services**: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 must bill that service on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837), using HCPCS/CPT procedure codes. These services require referral/authorization from the client's PCP. The provider must contact the PCP before providing these services. If a client requires hospitalization for dental treatment or for medical and surgical services billed on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837), the provider must contact the PCP for referral/authorization.

3. **Family Planning Services**: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

29-002.03 Mental Health and Substance Abuse Services: Mental health and substance abuse services (MH/SA) are provided by the MH/SA managed care plan for all NHC clients. This plan includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized by the Plan.
29-003 Payment for Services Provided by FQHCs: (NMAP) makes payment for services provided by federally-qualified health centers (FQHCs) as defined in section 1905(a)(2)(C) of the Social Security Act. NMAP will pay for services provided by FQHCs under a prospective payment system (PPS) that is in compliance with Section 1902(bb) of the Social Security Act. The Department assures that payment to an FQHC will result in payment to the center of an amount which is at least equal to the Prospective Payment System rate.

29-003.01 Definitions: The following definitions apply in this chapter.

**Encounter** means a face-to-face visit between a Medicaid-eligible patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

**Encounter Rate** means the all-inclusive PPS rate that the Department reimburses the FQHC for an encounter.

**Encounter Payments** means PPS rate paid to the FQHC by the Department multiplied by the number of encounters billed.

**Medicare Cost Report** means the report filed by each provider with its Medicare intermediary as required in the Medicare Rural Health Clinic and Federal Qualified Health Center Manual.

**Prospective Payment System (PPS)** means the payment system where in the reimbursement rate is paid for services provided.
29-004 Prospective Payment System

29-004.01 Prospective Payment System Base Rates: The Prospective Payment System base rate will be computed as follows:

1. Combine reasonable costs from the FQHC fiscal year 1999 and 2000 cost reports; and
2. Divide the costs by the Total Adjusted Visits from the two fiscal year cost reports (Form HCFA-222-92 Worksheet C, Part 1, Line 6; or Form HCFA-2552-96 Worksheet M-3, Line 6).

Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

29-004.02 Rates for New Providers: The Department will establish rates for a new FQHC entering the program after 1999 as follows:

1. For the initial year, the interim rate will be the average PPS rate of all FQHCs in Nebraska. The interim rate will be retroactively settled based on the FQHC’s initial cost report.
2. The FQHC’s individual PPS base rate will be computed later, using its initial cost report.
3. The PPS base rate will be updated annually based on the Medicare Economic Index (MEI).
29-004.03 FQHC Managed Care Payments: FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payment the FQHC receives from the MCE(s) and the payments the FQHC would have received under the PPS methodology.

29-004.03A At the end of each FQHC fiscal year, the Department will compare:

1. The total amount of supplemental and MCE payments received by the FQHC; to
2. The amount that the actual number of visits provided under the FQHC’s contract with the MCE(s) would have yielded under the PPS methodology.

The Department will pay the FQHC the difference between item 1 and item 2 if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC must refund the difference between item 1 and item 2 if the PPS payment is less than the total amount of the supplemental and MCE payments.

29-004.04 Non-FQHC Services: For non-FQHC services, NMAP will pay according to the Nebraska Medicaid Practitioners Fee Schedule.

29-004.05 Payment for Telehealth Services: Payment for telehealth services will be the Medicaid rate for the comparable in-person service. FQHC core services provided via telehealth technologies are not covered under the encounter rate.

29-004.05A Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs related to non-core services will be the lower of:

1. The provider’s submitted charge; or
2. The maximum allowable amount.

The Department will pay for transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmissions (see 471 NAC 1-006).

29-005 Cost Reports: Providers participating in the NMAP as FQHCs must submit an annual cost report to the Department.


Each FQHC must report and supply the Department with necessary documentation, cost reports, and any other documentation when requested.
29-006 Billing for FQHC Services: FQHCs must bill for their services on Form CMS-1450 (see 471-000-51) or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837). FQHCs must use the appropriate HCPCS/CPT procedure codes and revenue codes when billing for services.

FQHCs must bill for HEALTH CHECKS (Early and Periodic Screening, Diagnosis, and Treatment-EPSDT-Exams) on Form CMS-1500 (see 471-000-58) or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837).

FQHCs must bill all laboratory/radiology services and other non-FQHC services on the form CMS-1500 (see 471-000-58) or electronically using the standard health care claim; Professional transaction (ASC X12N 837) using the non-FQHC number.
30-000 Payment for Health Insurance Premiums

30-001 Introduction: The Nebraska Medical Assistance Program covers payment for health insurance premiums for individuals who are otherwise eligible for Medicaid when determined to be cost effective. This chapter contains the rules and regulations that apply to this benefit. Conditions of eligibility are addressed in Titles 468, 469, 470, 477, and 479.

30-001.01 Legal Basis: Sections 1905(a) and 1906 of the Social Security Act requires each state Medicaid program to provide this benefit.

30-001.02 Definitions: The following definitions apply to this benefit:

Cost Effectiveness: A determination, made by the Department, that the amount that the Nebraska Medical Assistance Program would pay for premiums, coinsurance, deductibles and other cost sharing obligations under a health plan, plus an amount for administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services.

Group Health Plan: Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of employees or former employees. A group health plan must meet S. 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Services Act, S. 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974.

Health Plan: Any health insurance plan that, in exchange for premiums paid, pays benefits for medical services. Excluding Medicare Part B premiums (see 471 NAC 1-007).

30-002 Covered Benefits: The Nebraska Medical Assistance Program covers payment of premiums for Medicaid-eligible enrollees in a cost effective health plan. NMAP also covers payment of all deductibles, co-insurance, and other cost sharing obligations under the health plan that are for services covered under NMAP.

30-002.01 Family Members: If a family member who is not eligible for Medicaid must be enrolled in the health plan to obtain coverage for the Medicaid-eligible client, NMAP covers payment only for the premiums; no other cost sharing expenses are covered. The family member may reside in a different household.
30-002.02 Services Covered by NMAP: A client's enrollment in a health plan does not change the client's eligibility for benefits under the Nebraska Medical Assistance Program. If services covered under NMAP are not covered by the health plan, the client may obtain those services from Medicaid-enrolled providers. Payment for those services is made according to the payment methodology currently in effect under NMAP.

If the client's health plan offers more services than covered under NMAP, NMAP does not pay for the deductibles, coinsurance, and other cost sharing obligations for non-covered services.

30-002.03 Medicare Enrollment: If the client is also eligible for Medicare Part B but is not enrolled in Medicare Part B, NMAP does not pay for the premiums or other cost sharing obligations to the health plan.

30-002.04 Cost Sharing Amounts Under NMAP: If the client is required to pay cost sharing amounts under NMAP, payment of the cost sharing amounts are not covered as a benefit under this chapter.

30-002.05 Available Resource: The health plan is considered an available third party resource.

30-003 Enrollment in a Group Health Plan: Group health plans usually limit an individual's enrollment period. If an individual who is already enrolled in a group health plan becomes Medicaid-eligible, NMAP buys into the group health plan as of the effective date of Medicaid eligibility.

30-003.01 Effective Date of Benefit: If a client is not eligible for coverage under a group health plan for a specified waiting period, NMAP buys into the group health plan as of the effective date of eligibility for the group health plan. Until the client is eligible to enroll or entitled to receive services under the group health plan, all Medicaid-covered services are covered and paid under the usual policies and procedures of NMAP.
30-003.02 Delayed Enrollment: If the availability for enrollment in the group health plan and eligibility for Medicaid do not coincide, the client/applicant shall apply for the group health plan (by completing the necessary forms if available). The enrollment application is held until open season and then the form is submitted.

The client/applicant is not eligible for Medicaid if s/he refuses to apply for enrollment in a group health plan. This ineligibility is effective until the next open season for group health plan enrollment.

30-004 Cost Effectiveness Determination: The Nebraska Medical Assistance Program (NMAP) determines the cost effectiveness of health plans using the following methodology:

1. Obtain information on the health plan available to the client. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the policy owners.

2. Using the Medicaid Management Information System (MMIS), obtain the total six-month estimated average Medicaid costs of persons like the applicant (age, sex, and category data). Adjust this amount for inflation.

3. Determine the amount of the total six-month Medicaid expenditures that are spent on the services covered by the individual policy, using the following categories: drugs, practitioner services (this includes physician services, durable medical equipment, other practitioners, etc.), inpatient hospital services, outpatient hospital services, and home health services.

4. Estimate the cost of coinsurance and deductibles up to the allowable amounts under the Nebraska Medical Assistance Program.

5. Determine the administrative cost to Medicaid for processing the health plan information by determining the average increase in cost per client for the six-month period.

6. Determine the cost to Medicaid with insurance by adding the following:
   a. The administrative cost determined under item 5;
   b. The coinsurance and deductible cost determined under item 4;
   c. The premium cost (The premium cost is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid. This accounts for Nebraska’s costs being based on "per client" data instead of "per eligible" data.); and
   d. The cost of non-covered services (subtract item 3 from item 2);

7. Compare the cost to Medicaid with insurance (item 6) to the estimated average Medicaid costs (item 2). If the cost to Medicaid with insurance is less than the estimated average Medicaid costs, the health plan is cost effective. If the cost to Medicaid with insurance is equal to or greater than the estimated average Medicaid costs, the health plan is not cost effective.
30-004.01 Exceptional Medical Costs: If the client provides documentation of on-going medical costs that exceed the estimated average Medicaid costs (see item 2 in 471 NAC 30-004), NMAP may determine that the health plan is cost effective.

30-004.02 Spenddown Cases: NMAP has determined that payment of premiums for a health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.

30-004.03 Non-Covered Benefits: NMAP has determined that payment of premiums for a health plan is not cost effective for the eligibility category of Aged.

NMAP does not pay premiums for health plans that are the court-ordered obligation of an absent parent.

30-005 Balance Billing: Medicaid pays only up to the amount allowed under the Nebraska Medical Assistance Program. For example, if a provider bills $50 for a service and the insurer pays $40, but the Medicaid allowable is $37, Medicaid will not make up the $10 difference between the billed amount and the insurance payment; NOR CAN THE PROVIDER BILL THE CLIENT. If the provider bills $50 and the insurance pays $37 and the Medicaid allowable is $40, Medicaid can pay the difference, up to the Medicaid allowable - in this case, Medicaid pays $3. THE PROVIDER CANNOT BILL THE CLIENT FOR THE DIFFERENCE BETWEEN THE MEDICAID PAYMENT AND THE BILLED AMOUNT.

30-006 Payment for Services: NMAP will pay the health insurance premium directly to the insurance carrier. If payment cannot be made directly to the carrier and the method of premium payment is payroll deduction, NMAP will arrange to pay the employer directly in lieu of the payroll deduction. If payment cannot be made directly to the carrier or employer, NMAP will reimburse the policyholder for the payroll deduction made for health insurance.

Some providers that participate in health plans may not be Medicaid participating providers. These providers will be encouraged to participate. Provider participation may be initiated through the submission of a bill for services. If providers refuse to bill Medicaid, NMAP may make payment directly to the client or financially responsible individual for the payment of coinsurance and deductible, up to the Medicaid allowable amount.
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 3-004.01 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 interdiscplinary 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.

<table>
<thead>
<tr>
<th>Form #</th>
<th>Form Title</th>
<th>Appendix Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM-5</td>
<td>Physician's Confidential Report</td>
<td>471-000-2</td>
</tr>
<tr>
<td>DM-5-MR-LTC</td>
<td>Long Term Care Evaluation for Intermediate Care Facility for the Mentally Retarded</td>
<td>471-000-5</td>
</tr>
<tr>
<td>DM-11</td>
<td>Annual Review - Census Sheet</td>
<td>471-000-30</td>
</tr>
<tr>
<td>DM-27C</td>
<td>Recommendation for Change of Care Classification or Services (Local Office Notification)</td>
<td>471-000-12</td>
</tr>
<tr>
<td>DM-27M</td>
<td>Long Term Care Facility Utilization Review Minutes</td>
<td>471-000-13</td>
</tr>
<tr>
<td>DM-28-MR</td>
<td>Intermediate Care Facility for the Mentally Retarded Utilization Review</td>
<td>471-000-16</td>
</tr>
<tr>
<td>Form #</td>
<td>Form Title</td>
<td>Reference</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>FA-66</td>
<td>Report of Long Term Care Facilities for Reimbursement</td>
<td>471-000-41</td>
</tr>
<tr>
<td>IM-8</td>
<td>Notice of Finding</td>
<td>471-000-68</td>
</tr>
<tr>
<td>MC-4</td>
<td>Long Term Care Facility Turnaround Billing Document</td>
<td>471-000-82</td>
</tr>
<tr>
<td>MC-9-NF</td>
<td>Prior Authorization for Nursing Facility Care</td>
<td>471-000-203</td>
</tr>
<tr>
<td>MC-10</td>
<td>Prior Authorization Document Adjustment</td>
<td>471-000-211</td>
</tr>
<tr>
<td>MC-81</td>
<td>Medical Assistance Long Term Care Provider Agreement</td>
<td>471-000-104</td>
</tr>
<tr>
<td>MCP-248</td>
<td>Remittance Advice</td>
<td>471-000-85</td>
</tr>
<tr>
<td>MCP-524</td>
<td>Electronic Claims Activity Report</td>
<td>471-000-85</td>
</tr>
<tr>
<td>PDS-38</td>
<td>Nebraska Medicaid Card</td>
<td>471-000-123</td>
</tr>
<tr>
<td>PDS-38B</td>
<td>Nebraska Health Connection ID Document</td>
<td>471-000-121</td>
</tr>
<tr>
<td></td>
<td>Health Care Claim: Institutional Transaction (ASC X12N 837)</td>
<td>471-000-49</td>
</tr>
<tr>
<td></td>
<td>Health Care Claim Status Request and Response Transaction (ASC X12N 276/277)</td>
<td>471-000-50</td>
</tr>
<tr>
<td></td>
<td>Health Care Eligibility Benefit Inquiry and Response Transaction (ASC X12N 270/271)</td>
<td>471-000-50</td>
</tr>
<tr>
<td></td>
<td>Health Care Services Review – Request for Review And Response Transaction (ASC X12N 278)</td>
<td>471-000-50</td>
</tr>
</tbody>
</table>
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.
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.

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.
31-004.01 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 -
   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 -
   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 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 Care: 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 -
   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, toothbrushes, 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 $0.28/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by $0.28/day.
3. For the rate period July 1, 2015 through June 30, 2016, prospective rates will be increased by $0.02/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:

<table>
<thead>
<tr>
<th>Staff Categories</th>
<th>Hours per Resident Day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Direct Care Staff</strong></td>
<td></td>
</tr>
<tr>
<td>- Aides, attendants, houseparents, counselors, house managers</td>
<td>6.5160</td>
</tr>
<tr>
<td><strong>Direct Care Admin.</strong></td>
<td></td>
</tr>
<tr>
<td>- QMRPs, residential service/ program coordinators, direct care supervisors</td>
<td>0.9105</td>
</tr>
</tbody>
</table>
### Hours per Resident Day

#### Active Treatment Services
- 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:

<table>
<thead>
<tr>
<th>Number of Residents</th>
<th>Number of Assistant Administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 100</td>
<td>None</td>
</tr>
<tr>
<td>101 to 200</td>
<td>1</td>
</tr>
<tr>
<td>201 to 300</td>
<td>2</td>
</tr>
<tr>
<td>301 to 400</td>
<td>3</td>
</tr>
<tr>
<td>401 to 500</td>
<td>4</td>
</tr>
<tr>
<td>501 and over</td>
<td>5</td>
</tr>
</tbody>
</table>

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.
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 predetermined 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:

<table>
<thead>
<tr>
<th>Item</th>
<th>Per Item Cost</th>
<th>Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toaster</td>
<td>$38</td>
<td>Dietary Supplies</td>
</tr>
<tr>
<td>30 Wastebaskets</td>
<td>$22 ($660 total)</td>
<td>Housekeeping Supplies</td>
</tr>
<tr>
<td>Calculator (bookkeeper)</td>
<td>$95</td>
<td>Administration Supplies</td>
</tr>
<tr>
<td>Pill Crusher</td>
<td>$62</td>
<td>Nursing Supplies</td>
</tr>
<tr>
<td>Wrench Set</td>
<td>$77</td>
<td>Plant Related Supplies</td>
</tr>
</tbody>
</table>

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.
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.

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

**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.

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

**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.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Variable for Basic Cost Bases</th>
<th>Variable for</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 40 Beds</td>
<td>Over 75 Beds</td>
</tr>
<tr>
<td>Moveable furniture</td>
<td>$1,000 per bed</td>
<td>$1,000 per bed</td>
</tr>
<tr>
<td>Dietary equipment</td>
<td>2 1/2% decrease to “Basic” for each bed</td>
<td>1% increase to “Basic” for each bed</td>
</tr>
<tr>
<td>Laundry equipment</td>
<td>“</td>
<td>$20,000</td>
</tr>
<tr>
<td>Heating equipment</td>
<td>“</td>
<td>$10,000</td>
</tr>
<tr>
<td>Air Cond. equipment</td>
<td>“</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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.

\[
\text{Depreciation Paid by State} = X (\text{Sales Price} - \text{Book Value})
\]

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:

<table>
<thead>
<tr>
<th>Data</th>
<th>Example A</th>
<th>Example B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Original Cost of Facility</td>
<td>Facility Sold For $500,000</td>
<td>Facility Sold For $350,000</td>
</tr>
<tr>
<td>2. Total Depreciation (S.L.) to date</td>
<td>Difference in the Sale Price</td>
<td>Difference in the Sales Price</td>
</tr>
<tr>
<td></td>
<td>Over the Book Value $200,000 ($500,000 - $300,000)</td>
<td>Over the Book Value $50,000</td>
</tr>
<tr>
<td>3. Book Value of Facility (1-2)</td>
<td>Medicaid Apportionment (35% X $200,000)</td>
<td>Medicaid Apportionment (35% X $50,000)</td>
</tr>
<tr>
<td>4. Depreciation Paid Under Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ratio of Depreciation Paid to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Depreciation (4/2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

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

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, D-1, F (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.
32-001 General Requirements

32-001.01 Eligibility: An individual is eligible for mental health and/or substance use treatment services set forth in this chapter when:

1. The individual has a diagnosis of a mental health or substance use disorder of sufficient duration and intensity to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association; and

2. The mental health or substance use disorder results in functional impairment that substantially interferes with or limits the individual’s role or functioning within his/her family, school or community. Coexisting conditions such as organic brain disorders, developmental disabilities, intellectual disability, autism spectrum disorders, or behavioral disorders, must be carefully evaluated in order to identify the functional impairments resulting from the mental health or substance use disorder diagnosis and those resulting from the coexisting condition. In the evaluation of coexisting conditions, evidence of the conditions will not automatically result in denial of eligibility; and

3. The services meet medical necessity criteria.

32-001.02 Medical Necessity: Medical necessity is defined as the need for treatment services which are necessary to diagnose, treat, cure or prevent regression of significant functional impairments resulting from symptoms of a mental health or substance use disorder diagnosis. Treatment services shall:

1. Be provided in the least restrictive level of care that is appropriate to meet the needs of the client; and

2. Be supported by evidence that the treatment improves symptoms and functioning for the individual client’s mental health or substance use disorder diagnosis; and

3. Be reasonably expected to improve the individual’s condition or prevent further regression so that the services will no longer be necessary; and

4. Be required for reasons other than primarily for the convenience of the client or the provider.

32-001.03 Family Component: Unless otherwise prohibited, providers shall involve the family in assessment, treatment planning, updating of the treatment plan, therapy and transition/discharge planning. Providers shall schedule meetings and sessions in a flexible manner to accommodate a family’s schedule, including weekends and/or evenings. Family involvement, or lack thereof, shall be documented in the clinical record. Parental/caregiver involvement in treatment is essential and evidence based practices which include parents in therapy are the expectation for treatment.

32-001.04 Cultural Competence: Providers shall be culturally competent. This includes awareness, acceptance and respect of differences and continuing self-assessment regarding culture.
32-001.05 Initial Diagnostic Interview: The Initial Diagnostic Interview shall include a history, mental status, and a disposition and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. If circumstances require, individuals such as family members, guardians or other supports may be interviewed to supplement the interview of the individual.

32-001.06 Practitioners Requiring Supervision: A Practitioner who is not eligible to practice independently and who provides mental health and/or substance use treatment services shall have a Supervising Practitioner:

1. Licensed Mental Health Practitioner
2. Provisionally Licensed Mental Health Practitioner
3. Registered Nurse (RN)
4. Provisionally Licensed Psychologist
5. Licensed Alcohol Drug Counselor (LADC)
6. Provisional LADC

32-001.06A A Supervising Practitioner shall be:

1. A licensed physician (M.D. or D.O.) who has completed a psychiatric residency or similar training program and preferably is Board Certified in psychiatry or addiction medicine, for any level of mental health or substance use services.
2. A licensed psychologist (Ph.D. or Psy.D.) for any level of mental health or substance use services except Psychiatric Residential Treatment Facility (PRTF).
3. A licensed independent mental health practitioner (LIMHP) for outpatient services, Intensive Outpatient and Community Treatment Aide (CTA) services only.

32-001.06B Responsibilities of Supervising Practitioner: A Supervising Practitioner shall:

1. Develop, approve and supervise the client's assessment and treatment plan. This requires a face-to-face assessment;
2. Direct patient care by reviewing and approving client specific treatment plans and progress notes within the timelines specified for each level of care, not to exceed 90 days; and
3. Assure treatment provided meets standards of care.

32-001.06C Reimbursement for Supervision: Face-to-face assessments and other services provided by the Supervising Practitioner, directly to the client, are reimbursable. Supervision is not reimbursable either by the Supervising Practitioner or the Practitioner who is being supervised.

32-001.07 Provider Enrollment: All providers of mental health and substance use treatment services shall submit a completed Medical Assistance Provider Agreement to Medicaid for approval. A separate application shall be submitted for each particular mental health and substance use treatment service.
32-001.07A Managed Care Enrollment: In order to be reimbursed for providing services to clients in managed care, providers shall be credentialed by and under contract with the Medicaid managed care behavioral health contractor.

32-001.08 Active Treatment: Treatment shall be provided in an interactive face-to-face environment with the client present and shall be focused on reducing or controlling the client's mental health and substance use disorder symptoms which cause functional impairments and promoting the client's movement to less restrictive treatment in the most time efficient manner consistent with sound clinical practice.

32-001.09 Treatment Plans: The Treatment Plan is a written, comprehensive plan of care to address mental health and substance use disorder symptoms identified in the Initial Diagnostic Interview. The Treatment Plan shall include transition and discharge planning and shall be amended as needed as treatment progresses. The Treatment Plan shall:

1. Be individualized to the client;
2. Include the specific symptoms or skills to be addressed;
3. Provide clear and realistic goals;
4. Include treatment objectives services, strategies, and methods of intervention to be implemented;
5. Describe the methods for evaluating both the client's progress and the performance of the practitioner facilitating the intervention; and
6. Estimate the length of time or number of sessions necessary to complete the treatment goals.

32-001.10 Transition and Discharge Planning: Providers shall begin and document transition and discharge planning at the time of admission or onset of treatment and continue to update the documentation throughout the treatment episode.

32-001.11 Coordination of Care: If the client receives services from more than one mental health and substance use provider, these providers shall coordinate their services.

32-001.12 Clinical Records: Each provider shall maintain a legible clinical record for each client that includes a complete record of all the treatment services rendered. The clinical record shall contain documentation sufficient to justify reimbursement and shall allow an individual not familiar with the client to evaluate the course of treatment. Failure to have sufficient documentation to justify the level of reimbursement may result in recouping of payments made for services lacking the documentation.

32-001.12A Progress Notes: Progress notes shall identify the client name, the name and title of the practitioner and the date of service. The progress note shall also identify the type of therapy, beginning and end date and time of the service delivered.

32-001.12B Record Retention: Clinical records shall be maintained for a minimum of seven years in a secure location.

32-001.12C Confidentiality of Records: Each provider shall ensure the confidentiality of clinical data, in accordance with state and federal law.
32-001.13 Location of Community Based Services: Community based mental health and substance use treatment services shall be provided in the client’s home or a professional environment conducive to client confidentiality and privacy.

32-001.14 Quality Assurance, Utilization Review and Inspection of Care (IOC): Providers shall fully cooperate with any reviews conducted by Medicaid or Medicaid’s designee to determine the quality of care and services provided. Providers shall have access to a copy of any final IOC report.

32-001.14A Response to IOC Reports: Within 15 days following the receipt of the IOC report, the provider shall respond in writing and submit a plan of correction for any identified findings and recommendations. The provider may request an extension of time to respond if needed.

32-001.15 Payment: Payment for services shall be based upon rates established by Medicaid, as described further throughout this chapter, and may be increased or decreased based on legislative appropriations or budget directives from the Nebraska Legislature. Providers may be required to report their costs on an annual basis or as needed.

32-001.16 Institutes for Mental Disease (IMD): Services provided to clients residing in an IMD shall not be Medicaid reimbursable except as provided in the regulations on PRTFs.
32-002 OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES

32-002.01 Covered Outpatient Mental Health and Substance Use Disorder Treatment Services: Covered services include:

1. Crisis Outpatient;
2. Client Assistance Program (managed care benefit only);
3. The Initial Diagnostic Interview;
4. Psychological Testing;
5. Comprehensive Child and Adolescent Assessment (CCAA);
6. Comprehensive Child and Adolescent Assessment Addendum;
7. Individual Psychotherapy;
8. Group Psychotherapy;
9. Family Psychotherapy;
10. Parent Child Interaction Therapy (PCIT);
11. Child-Parent Psychotherapy (CPP);
12. Individual Substance Use Disorder Counseling;
13. Group Substance Use Disorder Counseling;
14. Family Substance Use Disorder Counseling;
15. Conferences;
16. Community Treatment Aide;
17. Medication Management; and

32-002.02 Non-Covered Treatment Services: Services not covered include, but are not limited to:

1. Applied Behavioral Analysis (ABA);
2. Biofeedback Services;
3. Educational Services;
4. Behavior Modification and Planning;
5. Eye Movement Desensitization and Reprocessing (EMDR); and
6. Art, Play or Music Therapy.

32-002.03 Outpatient Services Providers: Outpatient services shall be provided by licensed practitioners whose scope of practice includes mental health and/or substance use disorder services.

32-002.04 Crisis Outpatient: Crisis outpatient individual or family therapy is an immediate, short-term treatment service provided to a client with urgent psychotherapy needs.

32-002.04A: The provider shall develop a short-term plan and shall identify ongoing treatment services if services appear to be medically necessary following stabilization. If services are to continue, the provider shall perform or arrange for an assessment and develop a treatment plan if one has not already been completed.

32-002.04B A client is eligible to receive crisis outpatient services of no more than five sessions per episode of crisis.
32-002.05 Client Assistance Program (CAP): The Client Assistance Program is a short-term, solution-focused set of interventions to assist a client in reducing or eliminating the current stressors that are interfering with the client’s daily living and wellbeing. The client is eligible for up to five services per calendar year. If it is determined that the client needs additional treatment, the provider shall perform an Initial Diagnostic Interview and formulate a treatment plan if this has not already been completed.

32-002.06 Initial Diagnostic Interview: An Initial Diagnostic Interview as set forth in 471 NAC 32-001.04.

32-002.07 Psychological Testing: Psychological Testing is the administration and interpretation of standardized tests used to assess an individual’s psychological or cognitive functioning. It assists in gaining an understanding of an individual’s diagnostic presentation and informs the appropriate course of treatment.

32-002.07A Testing services shall be administered and scored by a licensed psychologist or, under the supervision of a licensed psychologist, by a provisionally licensed psychologist, a licensed psychological assistant or a licensed psychological associate. All interpretation must be done by the licensed psychologist.

32-002.07B Psychological Testing must be prior authorized. Before psychological testing, the individual must be assessed to determine the need for and extent of the psychological testing. Testing may be authorized at the onset of treatment when it is necessary for reaching a diagnosis and/or helps resolve specific treatment planning questions. It may also occur later in treatment if the individual’s condition has not progressed and there is no clear explanation for the lack of improvement. Psychological testing that is available in schools is not covered by Medicaid.

32-002.08 Comprehensive Child and Adolescent Assessment (CCAA): A CCAA is a comprehensive assessment of a juvenile’s social, physical, psychological, and educational development and needs, including the recommendation for an individualized treatment plan when treatment is necessary and recommended.

32-002.08A A CCAA shall be covered for an individual under the age of 19 who is a Medicaid eligible ward of the State and who exhibits behaviors so severe that the individual has come to the attention of juvenile or county court.

32-002.08B A CCAA must be court-ordered. If the individual has received a CCAA in the previous 12 months and a subsequent evaluation is ordered, the provider shall obtain clinical information to complete an addendum to the current CCAA.

32-002.08C A CCAA shall be completed by a team of licensed and contracted practitioners led by a CCAA lead. The team shall include, at a minimum:

1. A psychiatrist;
2. A psychologist;
3. A physician to complete a wellness check; and
4. A Licensed Mental Health Practitioner (LMHP) or a Licensed Alcohol and Drug Counselor (LADC) or a Licensed Practitioner with expertise to conduct sex offender risk assessments.
32-002.08D Any CCAA provider conducting a substance use evaluation shall have completed the Comprehensive Adolescent Severity Inventory (CASI) training. All CCAA providers must be approved for the CCAA network by the State or its designee.

32-002.08E The CCAA lead shall complete a standardized report that coordinates all of the assessment information, makes a final recommendation for treatment and sequences the order of treatment if more than one recommendation is made. All treatment recommendations shall meet medical necessity criteria for the level of care recommendation. The Supervising Practitioner shall forward the report to the State or its designee who will forward the report to the court through the Office of Juvenile Services worker.

32-002.08F All components of the CCAA, including the standardized report with supporting documentation, shall be completed within ten working days of receipt of the request to complete the CCAA. The components are:

1. Records Search: A review and summary of the client’s records including past evaluations, past psychiatric treatment records, information from current providers, school records, child welfare records, juvenile probation and juvenile diversion records and other relevant historical information.

2. Collateral Contacts: A review and summary of information obtained from collateral contacts relevant to the comprehensive assessment. At a minimum, it shall include the client’s school, caseworker, care coordinator, probation/parole officer and past/present treatment providers.

3. Family Assessment: A current assessment addressing the family functioning, family dynamics and their impact on the client’s treatment needs. The family assessment shall include all parents identified by the client’s caseworker and shall be based on a direct face-to-face interview.

4. Comprehensive Adolescent Severity Inventory (CASI): Completion of all ten elements of the Comprehensive Adolescent Severity Inventory including:
   a. Health information;
   b. Stressful life events;
   c. Education;
   d. Alcohol and drug use;
   e. Use of free time;
   f. Peer relationships;
   g. Sexual behavior;
   h. Family/household members
   i. Legal issues; and
   j. Mental health.

5. Initial Diagnostic Interview: The Initial Diagnostic Interview includes a review of the first four components of the CCAA and the client’s wellness check, an interview with the client, an evaluation of current medications or recommendation for medication and its management, a mental status exam and a diagnosis on all five axes of the most current DSM, if appropriate.
6. Wellness Check: A current wellness check includes but is not limited to the following:
   
   a. Client's height, weight, blood pressure, pulse, temperature, vision test results, hearing test results and medical history.
   b. Any pertinent laboratory test completed by medical professionals.
   c. Sexually transmitted disease testing (excluding HIV testing) when ordered by medical staff (if HIV testing is indicated, it should be noted in the recommendation).

7. Psychological Testing: Psychological testing and other mental health assessments if clinically applicable and appropriate. Additional testing/assessment shall be authorized separately from the CCAA but shall be incorporated into the CCAA and completed under the direction of the Supervising Practitioner. This may include, but is not limited to, psychological testing, sexual risk offender assessment, eating disorder assessment and substance use disorder assessments.

32-002.08G The standardized report shall contain and be signed by the CCAA lead:

1. Demographics;
2. A list of records reviewed and information sources contacted;
3. Presenting problem;
4. Medical history;
5. School/work/military history;
6. Alcohol/drug history and assessment summary;
7. Legal history;
8. Family/social/peer history;
9. Psychiatric/behavioral treatment history, including psychotropic medication;
10. Collateral information (family/friends/criminal justice/victim issues);
11. Case formulation/Clinical impression;
12. Psychological testing and specialty assessment results;
13. Substance use treatment recommendations, if applicable (include primary/ideal level of care recommendation, available level of care, barriers to ideal recommendations and client/family response to recommendations); and
14. Mental health treatment recommendations, if applicable.

32-002.08H The Supervising practitioner of the CCAA agency shall complete all necessary requests for authorization, treatment referrals and written applications, as required for services such as, but not limited to, PRTF, THGH or PRFC. CCAA staff shall also participate in all peer and reconsideration reviews associated with these requests, as appropriate.

32-002.08I A community-based evaluation shall be completed in the client's home, the clinician's office or another setting in the community where the client normally resides. If this is not possible due to the distance between the client's residence and the CCAA provider, the evaluation may be completed in a residential facility arranged by the provider. Residential evaluations may include a maximum of three days room and board payment and must be prior authorized by the State or its designee.
32-002.09 CCAA Addendum: If the court requests a revised CCAA and the request is within 12 months of the original CCAA, a CCAA addendum may be authorized by the State or its designee. The addendum shall clarify or update the treatment needs and/or recommendations as well as provide information not included in the original CCAA.

32-002.10 Individual Psychotherapy: A face-to-face active treatment session between a client and an appropriately licensed practitioner for the purpose of improving the mental health symptoms that are significantly impairing the client’s functioning in at least one life domain such as family, social, occupational or educational.

32-002.10A The treatment plan shall identify the diagnosis that is the focus of treatment, the specific target symptoms, the goals, the frequency and the estimated duration of the service and shall be individualized according to the client’s needs and the identified symptoms experienced by the client. Services must be treatment focused and not rehabilitative or habilitative in nature.

32-002.10B The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Services for prevention, maintenance, socialization or skill building.

32-002.11 Group Psychotherapy: A face-to-face treatment session between a client and a licensed practitioner in the context of a group setting of 3-12 clients. Group psychotherapy shall be provided as an active treatment service for a primary psychiatric disorder in which identified treatment goals, frequency and duration of service are a part of the client's active treatment plan and there is reasonable expectation that group psychotherapy will improve the client's psychiatric symptoms so that therapy will no longer be needed.

32-002.11A The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Treatment for prevention, maintenance, socialization or skill building.

32-002.12 Family Psychotherapy: A face-to-face treatment session in which an identified client and the client's nuclear or extended family interact with a practitioner for the purpose of improving the functioning of the family system and decrease or eliminate the mental health symptoms experienced by the family. Depending on the clinical appropriateness, it is expected that all members of the family residing in the same household as the client participate in family therapy. Others significant to the client or the family may also be in attendance at Family Psychotherapy if their attendance will be meaningful in improving family functioning.

32-002.12A The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Treatment for prevention, maintenance, socialization or skill building.
32-002.13 Parent Child Interaction Therapy (PCIT): An evidence-based service provided to children age 2-12. This therapy places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. As such, it is used to treat clinically significant disruptive behaviors due to the child’s primary mental health disorder.

32-002.13A The goals, frequency and duration of the service shall be identified in the child’s treatment plan and shall vary according to the child’s individual needs and the identified symptoms experienced by the child. Services must be treatment-focused and not rehabilitative or habilitative in nature. Young children should receive PCIT services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.

32-002.13B There shall be a reasonable expectation that PCIT Therapy will improve the child’s psychiatric symptoms so that the services will no longer be necessary.

32-002.13C The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Services for maintenance, socialization or skill building.
3. Services not following the PCIT evidence-based treatment model or performed by an individual not appropriately trained in PCIT.

32-002.14 Child-Parent Psychotherapy (CPP): An evidence-based service provided to children birth to age 5, who have experienced at least one traumatic event (e.g. maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including post-traumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child’s sense of safety, attachment, and appropriate affect and improving the child’s cognitive, behavioral, and social functioning.

32-002.14A The goals, frequency and duration of the service shall be identified in the child’s treatment plan and shall vary according to the child’s individual needs and the identified symptoms experienced by the child. Services must be treatment-focused and not rehabilitative or habilitative in nature. Young children should receive CPP services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.

32-002.14B There shall be a reasonable expectation that CPP therapy will improve the child’s psychiatric symptoms so that the services will no longer be necessary.

32-002.14C The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Services for maintenance, socialization or skill-building.
3. Services not following the CPP evidence-based treatment model or performed by an individual not appropriately trained in CPP.
32-002.15 Individual Substance Use Disorder Counseling: A face-to-face counseling session between a client and a licensed practitioner for a primary substance use disorder. Individual substance use disorder counseling shall be designed to assist the client in achieving and maintaining abstinence from alcohol and drug abuse. This includes motivational enhancement and interventions defined in the Adolescent Placement Criteria for Level 1 in the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for Treatment of Substance-Related Disorders (current version).

32-002.15A Outpatient substance use disorder counseling shall reasonably be expected to improve the symptoms of the client’s substance use disorder which are identified in the client’s treatment plan.

32-002.15B The treatment plan shall identify the diagnosis that is the focus of treatment, the specific target symptoms, goals, the frequency and the estimated duration of the service and shall be individualized according to the client’s needs and the identified symptoms experienced by the client. Services must be treatment focused and not rehabilitative or habilitative in nature.

32-002.15C The following services are not covered:
   1. Services that are primarily supportive, social or educational in nature.
   2. Services for prevention, maintenance, socialization or skill building.

32-002.16 Group Substance Use Disorder Counseling: A face-to-face counseling session during which a practitioner directs interactions between 3-12 clients who have a substance use disorder diagnosis for the purpose of all clients achieving abstinence from alcohol and drug abuse.

32-002.16A The definition of group substance use disorder counseling and the criteria for determining whether outpatient group substance use disorder counseling is the most appropriate treatment are listed in the Adolescent Placement Criteria section for Level 1 services in the American Society of Addiction Medicine (ASAM) Placement Criteria for Treatment of Substance Related Disorders (current version).

32-002.16B The following services are not covered:
   1. Counseling that is primarily supportive, social or educational in nature.
   2. Counseling for prevention, maintenance, socialization or skill building.

32-002.17 Family Substance Use Disorder Counseling: A face-to-face treatment session between an identified client and the client’s nuclear or extended family and a licensed practitioner. The services shall focus on the client’s substance use disorder needs and the family as a system and shall include a comprehensive family assessment. Depending on the clinical appropriateness, it is expected that all members of the family residing in the same household as the client participate in family substance use disorder counseling. The specific objectives shall be to increase the functional level of the identified client and the client’s family related to substance use.
The service shall be for a client with a substance related disorder and meet the
criteria of Level I treatment according to the youth criteria of the Patient Placement Criteria
for Treatment of Substance-Related Disorders of the American Society of Addiction
Medicine (ASAM).

The following services are not covered:

1. Counseling that is primarily supportive, social or educational in nature.
2. Counseling for prevention, maintenance, socialization or skill building.

Conferences: Conferences with family or other persons advising them on how to
assist the client can be covered under limited circumstances.

These circumstances must demonstrate a need for the therapeutic involvement
and include:

1. Following Psychiatric Testing, or
2. As required during the provision of MST services, or
3. As a treatment intervention, identified in the client’s treatment plan and
   requiring a progress note.

All conferences must be prior approved by Medicaid or its designee.

Scheduling appointments and reporting client progress are not considered
conferences and shall not be reimbursable. Supervisory meetings or care coordination
meetings are not conferences and shall not be reimbursable.

Community Treatment Aide Services: Community Treatment Aide (CTA) services
are supportive and psychoeducational interventions designed to assist the client and parents or
primary caregivers to learn and rehearse the specific strategies and techniques that can
decrease the severity of, or eliminate, symptoms and behaviors associated with the client’s
mental illness that create significant impairments in functioning. The client’s CTA plan shall be
a part of the comprehensive treatment plan developed by the client’s outpatient psychotherapy
provider and be developed in close collaboration with the therapy provider. The CTA
interventions, the client’s progress and modifications to the CTA plan shall be reviewed and
approved by the outpatient therapist and shall be documented by the CTA and the therapist.

CTA services shall be provided primarily in the client’s natural environment, i.e.,
home or foster home, but may also include other appropriate community locations where the
parent or caregiver are present. CTA services shall not be used in place of a school aide or
other similar services not involving the parent.

CTA services shall be delivered under the direction and supervision of the
therapist providing family and/or individual therapy on a regular basis to the client and the
client’s caregiver/family. The CTA and the licensed therapist shall coordinate care and
document their collaboration at least every other week to ensure the CTA activities delivered
to the client remain relevant to the client’s treatment plan.
Activities designed by CTA providers may include activities related to:

1. Developing a written safety plan with input from the therapist, the client and the parents or caregivers.
2. Instructing the parents or caregivers in de-escalation techniques and strategies.
3. Teaching and modeling appropriate behavioral treatment interventions and techniques and coping skills with the client and the client’s parents or caregivers.
4. Collecting information about medication compliance and developing reminder strategies and other interventions to enhance compliance as needed.
5. Assisting parents or caregivers with reporting medication effects, side effects, concerns regarding side effects or compliance problems and other information regarding progress and barriers to the treating therapist and the prescribing physician.
6. Teaching and modeling proper and effective parenting practices.
7. Providing training and rehabilitation regarding basic personal care and activities of daily living.

CTA services shall be prior authorized by the State or its designee in order to be eligible for reimbursement.

CTA agencies shall have a program description approved by the State or its designee.

The CTA program/clinical director may be a licensed physician (MD or DO) who has completed a psychiatric residency or similar training program and preferably is Board Certified in psychiatry or addiction medicine, psychologist, Licensed Mental Health Practitioner (LMHP), a registered nurse (RN), an APRN or LMHP. The director shall have two years of professional experience in mental health and/or substance use disorder treatment of individuals under the age of 21.

The CTA therapist shall be a licensed physician (MD or DO) who has completed a psychiatric residency or similar training program and preferably is Board Certified in psychiatry or addiction medicine, psychologist, LMHP, LMHP or APRN. The CTA may be a PLMHP or a provisionally licensed psychologist only if employed by an accredited organization or by exception by the Department or its designee. The CTA therapist shall meet all the requirements for outpatient therapy and must coordinate and collaborate with the CTA direct staff.

The CTA direct care staff shall:

1. Have a bachelor’s degree in psychology, social work, child development or a related field and the equivalent of one year of full-time experience in direct child/adolescent services or mental health and/or substance use disorder services. Equivalent time in graduate studies may substitute for work experience; or
2. Have two years post-high school education in the human services or related fields and a minimum of two years’ experience in direct child/adolescent services or mental health and/or substance use disorder services.
Prior to allowing staff to treat clients, CTA agencies shall gather information from abuse and neglect registries and conduct criminal background checks of all potential CTA workers and shall assure that all workers have completed the CTA agency’s basic training program.

The unit of service for CTA staff persons shall be 15 minutes.

Medication management is the service provided by a physician, physician assistant or advanced practice registered nurse focused on the monitoring and prescribing of psychopharmacologic agents. The service shall include relevant history, a mental status examination and medical decision making regarding initiating or adjusting pharmacological agents.

A sex offender risk assessment is a structured evaluation for the purpose of recommending whether sex offender specific treatment is necessary, the most appropriate intensity, frequency and type(s) of sex offender treatment and to recommend safety parameters, including the level of supervision and monitoring needed during treatment. The resulting recommendations should also address treatment needs for medical, mental health and or substance use disorder conditions that are diagnosed during the assessment. The assessment is not a forensic evaluation.

Practitioners providing this assessment shall provide a written report which includes the components listed below that support the treatment recommendations.

The report shall be signed by the psychologist although parts of the assessment may be conducted by others who operate within the scope of their license and who are under the supervision of the signing psychologist.

The components for a sexual offender risk assessment include demographic, biopsychosocial, psychological assessment results and treatment recommendations as follows:

1. Demographic Information: Reasons for the assessment, police reports and other relevant court documents, clinical interview of client, family members and other collateral contacts, Initial Diagnostic Interview and review of previous mental health and substance use disorder treatment and psychological testing records.
2. Biopsychosocial Information: Background information, family relations and dynamics, family response to the current symptoms and problems, social functioning, school/academic history, substance use disorder history, legal history, mental health treatment history, sexual offense history, trauma /victimization history and personal strengths.
3. Psychological Evaluations: Level of cognitive/adaptive functioning, personal and behavior factors, sex offender risk assessment using both static and dynamic factors, sexual misconduct patterns, perception /understanding/motivation/ empathy for victim, current supervision and access to victim as well as protective factors and strengths.
4. Case Formulation and Treatment Recommendations: An integrated discussion of the relevant factors in determining the treatment recommendations and an assessment of the client’s current risk to reoffend.
32-003. Treatment Crisis Intervention Services: Crisis intervention services are available to clients age 20 or younger when the treatment of a condition needing care leads to a HEALTH CHECK (EPSDT) screen and the treatment is clinically necessary. Crisis intervention services are appropriate for a family in the midst of a child/adolescent mental health or substance abuse crisis. The interventions focus on reducing stress and helping resolve the crisis in a positive manner, and facilitating the client's involvement to treatment.

Crisis intervention services must meet all requirements in 471 NAC 32-001. All crisis intervention service providers must facilitate a referral for a complete HEALTH CHECK (EPSDT) screen within eight weeks of the crisis intervention. This referral must be documented in the client's clinical record.

Crisis intervention services must be family-centered, community-based, developmentally appropriate, culturally competent, and must take into account the individual needs of clients age 20 and younger.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-003.01 Types of Crisis Intervention Services: One of the following services must be included in a crisis intervention program to be approved for participation in the Nebraska Medical Assistance Program.
32-003.01A Non-Residential Crisis Intervention: Non-residential crisis intervention services are provided to the family and client outside of a residential or institutional setting. This service includes supportive services therapy, brief assessment, and coordination services to help a family alleviate a crisis. These services must be directed by a supervising practitioner and psychiatric consultation must be readily available. Some assessment and intervention activities may be carried out by a clinical professional (see 471 NAC 32-001.04, item 2) who is acting within his/her scope of practice under the direction of a supervising practitioner.

The provider must have the capacity to respond to the family to unscheduled crisis intervention contacts 24 hours a day, seven days a week.

Providers of crisis intervention services must facilitate the referral to or provide the Initial Diagnostic Interview if it has not already occurred.

32-003.01B Day Residential Crisis Intervention: Day residential crisis intervention services are provided to families when a safe and secure setting is needed to provide a therapeutic milieu for a child or adolescent for up to 23 hours and 59 minutes. This level is used when a brief stay in a secure setting will facilitate a de-escalation of the crisis. These services must be directed by a supervising practitioner with access to psychiatric consultation. The milieu and direct care interventions may be staffed by clinical professionals (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the Initial Diagnostic Interview if it has not already occurred.

32-003.01C Residential Acute Crisis Intervention: Residential acute crisis intervention services are available to children and adolescents experiencing acute psychiatric crisis. The program provides crisis treatment and close supervision to stabilize a client and facilitate admission to the most appropriate treatment setting. These services must be directed under the cooperative supervision of a physician and other licensed practitioner of the healing arts. The milieu and direct care interventions may be staffed by clinical professionals (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the Initial Diagnostic Interview, if it has not already occurred.
32-003.02 Standards for Participation as a Provider of Crisis Intervention Services: Programs shall meet the following standards to participate in the NMAP as a provider of crisis intervention service in addition to the standards listed in 471 NAC 32-001.03.

32-003.02A Provider Agreement: The provider shall submit the following with Form MC-19 (non-hospital) or Form MC-20 (hospital):

1. A written overview of the program’s philosophy and objectives of treating youth including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of qualification, education, and experience of each staff member providing treatment and the supervising practitioner and the therapeutic services each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. A program overview, including admission criteria, staff training information, etc.; and
   f. Any other information requested by the Department;
2. Copies of licensure and certification, through the Nebraska Department of Health and Human Services, Division of Public Health, JCAHO, COA, AOA and/or CARF as appropriate.

32-003.02B Staffing Standards for Participation: An agency providing crisis intervention services for children and adolescents shall meet the following staffing standards to participate in NMAP:

1. All services must be provided under the supervision of the supervising practitioner. This practitioner must be available at all times for consultation or face-to-face client assessment.
2. Direct intervention services must be provided by a clinical staff person who is acting within his/her scope of practice (see 471 NAC 32-001.04).
32-003.02C Location of Services: Crisis intervention services may be provided in any of the following locations:

1. The client's home;
2. A physician's private office;
3. A community mental health program which meets the criteria for approval by JCAHO or is accredited by CARF, COA, or AOA, and is appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
4. A hospital licensed and certified by the State of Nebraska which is accredited by JCAHO or AOA and has in effect a utilization review plan applicable to all Medicaid clients;
5. The private office of a licensed practitioner of the healing arts who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
6. The client's school;
7. Other appropriate locations to meet the client needs for intervention;
8. A treatment foster home that is part of an agency enrolled to provide treatment foster care through Medicaid; or
9. A facility enrolled as a residential treatment center or therapeutic group home under this chapter (Mental Health and Substance Abuse Services for Children and Adolescents).

32-003.02D Annual Update: The provider shall submit the following information on an annual basis:

1. An overview of any changes in the program including any new services;
2. A current list of staff; and
3. Current copies of all licenses, letters of accreditation, and certifications.

32-003.03 Covered Services: Payment for crisis intervention services under the Nebraska Medical Assistance Program is limited to services for clinically necessary primary psychiatric diagnoses. The Department covers the following crisis intervention services:

1. Active treatment, which must be:
   a. Provided under the supervision of the supervising practitioner by clinical staff members acting within their scope of practice (see 471 NAC 32-001.04); and
   b. Reasonably expected to improve the client's condition or resolve the crisis. The treatment interventions must, at a minimum, be designed to reduce or control the client's symptoms to facilitate the resolution of a crisis or prevent the need for care in a more restrictive level of care.
32-003.03A Special Treatment Procedures in Crisis Intervention Services: If a child/adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. For Crisis Intervention Services provided in Treatment Foster Care, Residential Treatment Centers, or Treatment Group Homes, please refer to the sections covering those services. For Crisis Intervention Services provided in the child/adolescent's home, school, or other appropriate location, Special Treatment Procedures is limited to physical restraint. Mechanical restraints and pressure point tactics are not allowed. Parents, the legal guardian, or the Department case manager must approve use of these procedures and must be informed within 24 hours each time they are used.

Facilities must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring intervention.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

32-003.04 Admission Criteria: The provider of crisis intervention services shall develop admission criteria for the types of services they provide. The admission criteria must be approved by the Department Medicaid staff as part of the provider enrollment.
32-003.05 Documentation in Client's Medical Record: Providers of crisis intervention services must follow the standards for Clinical Records specified in 471 NAC 32-001.05.

Clinical records for crisis intervention services must also include, at a minimum, the following:

1. The referral source and description of the crisis;
2. The provider's plan to facilitate referrals to the appropriate ongoing care for the family; and
3. The follow-up contacts with the client and/or family.

32-003.06 Limitations: NMAP limits payment for crisis intervention to medically necessary services, subject to the Department's utilization review.

This period includes an average crisis resolution period of three to five days with an occasional need for up to seven days when the client's condition dictates. Payment for crisis intervention services is not available for services past seven days.

32-003.07 Payment for Crisis Intervention Services: Payment for crisis intervention services is made according to the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

If crisis intervention services are provided in the home between the hours of 10:00 p.m. and 8:00 a.m., the fee will be paid at one and one half times the regular rate. This shift differential is only available for unscheduled emergency services that are part of a crisis intervention service.
32-004 Mental Health and Substance Use Disorder Day Treatment Services: Day treatment services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care is identified as part of a Substance Use Disorder Assessment. These services are part of a continuum of care designed to prevent hospitalization or to facilitate the movement of the client in an acute psychiatric setting to a status in which the client is capable of functioning within the community with less frequent contact with the mental health or substance abuse provider.

Day treatment services must be community based, family centered, culturally competent, and developmentally appropriate.

Day treatment services must meet all requirements in 471 NAC 32-001.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-004.01 Covered Day Treatment Services: Day treatment programs shall provide the following mandatory services and at least two of the following optional services. Payment for both mandatory services and optional services is included in the rate for day treatment. Individual services to the client by a supervising practitioner that are not administrative in nature and are clinically necessary will be considered for payment when billed by the supervising practitioner. Providers shall not make any additional charges to the Department or to the client.
32-004.01A Mandatory Services: The following services must be included in a program for day treatment to be approved for participation in the Nebraska Medical Assistance Program. See 471 NAC 32-001 for definitions.

1. **Medically Necessary Psychotherapy and Substance Abuse Counseling Services**: These services must demonstrate active treatment of a patient with a serious emotional disturbance. These services are subject to program limitations.
   a. Individual Psychotherapy or Substance Abuse Counseling;
   b. Group Psychotherapy or Substance Abuse Counseling;
   c. Family Psychotherapy or Substance Abuse Counseling; and
   d. Family Assessment;

2. **Medically Necessary Nursing Services**: Medical services provided by a Qualified Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document and approved by the supervising practitioner.

3. **Medically Necessary Psychological Diagnostic Services**: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a Licensed Psychologist, Specially Licensed Psychologist or a psychology resident acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.

4. **Medically Necessary Pharmaceutical Services**: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside facility or provider. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, or licensed practical nurse.

5. **Medically Necessary Dietary Services**: If meals are provided by a day treatment program, services must be supervised by a registered dietitian, based on the client's individualized diet needs. Day treatment programs may contract for these services through an outside facility or provider.

6. Transition and discharge planning that meets the requirements of 471 NAC 32-001.07A.
32-004.01B Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy. In appropriate circumstances, occupational therapy may be covered if prescribed as an activities therapy in a day treatment program:

1. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
   a. Recreational Therapy;
   b. Speech Therapy;
   c. Occupational Therapy;
   d. Vocational Skills Therapy;
   e. Self-Care Services: Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.

2. Psychoeducational Services: Therapeutic psychoeducational services may be provided as part of a total program. Therapeutic psychoeducational services must be provided by teachers specially trained to work with child and adolescents experiencing mental health or substance abuse problems. These services may meet some strictly educational requirements, but must also include the therapeutic component. Professionals providing these services must be appropriately licensed and certified for the scope of practice.

3. Social Work Services by a Bachelor's Level Social Worker: Social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment, i.e., case management type services.

4. Crisis Intervention (may be provided in home);
5. Social Skills Building;
6. Life Survival Skills; and

7. Substance abuse prevention, intervention, or treatment by an appropriately certified alcohol/drug abuse counselor.
32-004.01C Educational Program Services: Services, when required by law, must be available, though not necessarily provided by the day treatment program. Educational services must be only one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the Nebraska Medical Assistance Program (Medicaid), and do not apply towards the three hours or six hours of therapeutic services.

32-004.01D Special Treatment Procedures in Day Treatment: If a child/adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in day treatment are limited to physical restraint, and locked time out (LTO). Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardian or the Department case manager must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used.

Facilities must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO, or physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

32-004.02 Standards for Participation

32-004.02A Provider Standards: Providers of day treatment services shall meet the following standards:

1. A community mental health or substance abuse program providing day treatment must meet the following standards -
   a. A community-based treatment facility appropriately licensed as determined by the Department of Health and Human Services, Division of Public Health;
b. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or the American Osteopathic Association (AOA). Agencies that have applied for accreditation may be enrolled on a provisional status; and

2. A psychiatric or substance abuse hospital providing day treatment must -
   a. Be maintained for the care and treatment of patients with primary psychiatric or substance abuse disorders;
   b. Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
   c. Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
   d. Have licensed and certified psychiatric or substance abuse beds;
   e. Meet the requirements for participation in Medicare; and
   f. Have in effect a utilization review plan applicable to all Medicaid clients.

3. A licensed and certified hospital which provides acute care services and which -
   a. Is maintained for the care and treatment of patients with acute medical disorders;
   b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
   c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
   d. Meets the requirements for participation in Medicare for acute medical hospitals;
   e. Has in effect a utilization review plan applicable to all Medicaid clients; and
   f. Has adequate staff to meet the requirements of the mental health or substance abuse day treatment standards.

4. If day treatment services will be provided in a school, the school must have a written contract with a mental health or substance abuse program that meets these standards community mental health program or licensed hospital. This contract shall demonstrate the working relationship between the school and the community mental health or substance abuse program to provide the day treatment service.
32-004.02B  Service Standards:

1. The program must provide a minimum of three hours of services five days a week, which is considered a half day for billing purposes. Six hours a day of services is considered a full day of services. Services may not be prorated for under three (or six) hours of services, but may be for up to 12 hours of service.

2. A designated supervising practitioner must be responsible for the care provided in a day treatment program. The supervising practitioner must be present on a regularly-scheduled basis and must assume responsibility for all clients. If the supervising practitioner is present on a part-time basis, one of the clinical staff professionals acting within the scope of practice standards of the Nebraska Department of Health and Human Services, Division of Public Health (see 471 NAC 32-001.04) shall assume delegated professional responsibility for the program and must be present at all times when the program is providing services.

Psychotherapy and substance abuse counseling services must be provided by clinical staff (see 471 NAC 32-001.04) who are operating within their scope of practice and under the direction of the supervising practitioner. The supervising practitioner's personal involvement must be documented in the client's clinical record.

3. A licensed psychologist, physician, or doctor of osteopathy may refer a client to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner.

4. All treatment must be conducted under the direction of the supervising practitioner in charge of the program;

5. Admission Criteria: The following criteria must be met for a client's admission to a day treatment program:

a. The client must have sufficient need for active treatment at the time of admission to justify the expenditure of the client's and program's time, energy, and resources;

b. Of all reasonable options for active treatment available to the client, treatment in this program must be the best choice for expecting a reasonable improvement in the client's condition;

6. Before the client is admitted to the program, a supervising practitioner shall complete an Initial Diagnostic Interview to validate the appropriateness of care.

7. Treatment Plan: The program supervising practitioner shall determine the diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.

The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
The multi-disciplinary team shall complete the treatment plan within the first 14 days after the client's admission to the program. The plan must be reviewed and revised by the multi-disciplinary team, including the supervising practitioner, at least every 30 days or more often if necessary.

Changes in the treatment plan must be noted on the treatment planning document. An updated treatment plan must be completed every 30 days, or more frequently if necessary, to reflect changes in treatment needs.

The treatment plan must be signed by the supervising practitioner for day treatment services.

The treatment plan review must be documented on the treatment plan, if required, and in the medical records.

8. The supervising practitioner must meet personally with the client for evaluation every 30 days, or more often, as clinically necessary. Reimbursement for the 30-day update visit is not included in the day treatment per diem and can be reimbursed separately.

9. Every 30 days a utilization review must be conducted per 471 NAC 32-004.07. This review must be documented on the treatment plan, and the facility's treatment plan review form. Utilization review is not required for the calendar month in which the client was admitted.

10. The program must have a description of each of the services and treatment modalities available. This includes psychotherapy services, substance abuse counseling, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other day treatment services.
   a. The program must have a description of how the family-centered requirement in 471 NAC 32-001 will be met, including a complete description of any family assessment and family services.
   b. The program must have a description of how the community-based requirement in 471 NAC 32-001 will be met.
   c. The program shall state the qualifications, education, and experience of each staff member and the therapy services each provides.
   d. The program must have a daily schedule covering the total number of hours the program operates per day. The schedule must be submitted to the Department for approval. The program must be fully staffed and supervised during the time the program is available for services, and must provide at least three hours of approved treatment for each day services are provided. This schedule must be updated annually, or more frequently if appropriate.
11. Outpatient Observation: When appropriate for brief crisis stabilization, outpatient observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used as follows:

An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone). If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed and whether s/he remained in the hospital past midnight or the census-taking hour, and all inpatient prior-authorization requirements apply.

12. The program must have a written plan for immediate admission or readmission for appropriate inpatient services, if necessary. The written plan must include a cooperative agreement with a psychiatric or substance abuse hospital or distinct part of a hospital, as outlined in 471 NAC 32-008. A copy of this agreement must accompany the provider application and agreement.

32-004.03 Provider Agreement: A provider of day treatment services shall complete a provider agreement and submit the form to the Department for approval. The provider shall attach to the provider agreement a written overview of the program including philosophy, objectives, policies and procedures, and documentation of the requirements in 471 NAC 32-001 are met. Staff must meet the standards outlined in 471 NAC 32-001.04, and:

1. Community mental health or substance abuse programs and licensed health clinics shall complete Form MC-19, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document must also be submitted. Satellites of community programs shall bill the Department through their main community program, unless the satellite has a separate provider number under Medicare. A satellite of a community program that has a separate provider number under Medicare shall complete a separate provider agreement. All claims submitted to the Department by these satellites must be filed under the satellite’s Medicaid provider number. The facility must have in effect a utilization review plan applicable to all Medicaid clients.

2. Hospitals shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document must also be submitted.

32-004.03A Annual Renewal/Update: The program shall renew the provider agreement, program overview, and cost report annually and whenever requested by the Medicaid Division.
32-004.04 Coverage Criteria for Mental Health or Substance Abuse Day Treatment Services: The Nebraska Medical Assistance Program covers day treatment services for clients 20 and younger when the services meet the requirements in 471 NAC 32-001 and the client has participated in a HEALTH CHECK (EPSDT) screen.

Day treatment services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.

The client must be observed and interviewed by the supervising practitioner at least once every 30 days, or more frequently if medically necessary, and the interaction must be documented in the client's clinical record.

32-004.04A Services Not Covered Under NMAP: Payment is not available for day treatment services for clients -

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-002.01F, Services Provided Outside Nebraska;
2. In long term care facilities;
3. Whose needs are social or educational and may be met through a less structured program;
4. Whose primary diagnosis and functional impairment is acutely psychiatric in nature and whose condition is not stable enough to allow them to participate in and benefit from the program; or
5. Whose behavior may be very disruptive and/or harmful to other program participants or staff members.

32-004.05 Documentation in the Client's Clinical Record: All documents submitted to NMAP must contain sufficient information for identification (i.e., client's name, dates of service, provider's name). In addition to the requirements of 471 NAC 32-001.05, each client's medical record must contain the following documentation:

1. The supervising practitioner's orders;
2. The treatment plan;
3. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the team's progress notes must be recorded at least daily. The progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan, as indicated by the client's condition, and discharge planning.
4. Documentation indicating compliance with all requirements in 471 NAC 32-001;
5. Records of the treatment plan review by the multi-disciplinary team including attendees and decisions;
6. The program's utilization review committee's abstract or summary; and
7. The discharge summary.
32-004.06 Transition and Discharge Planning: Each provider must meet the 471 NAC 32-001.07A requirements for transition and discharge planning.

32-004.07 Utilization Review (UR): Each program is responsible for establishing a utilization review plan and procedure which meets the following guidelines. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.

32-004.07A Components of UR: Utilization review must provide -

1. Timely review (at least every 30 days) of the medical necessity of admissions and continued treatment;
2. Utilization of professional services provided;
3. High quality patient care; and
4. Effective and efficient utilization of available health facilities and services.

32-004.07B UR Overview: An overview of the program's utilization review process must be submitted with the provider application and agreement before the program is enrolled as a Medicaid provider. The overview must include -

1. The organization and composition of the utilization review committee which is responsible for the utilization review function;
2. The frequency of meetings (not less than once a month);
3. The type of records to be kept; and
4. The arrangement for committee reports and their dissemination, including how the program and supervising practitioner is informed of the findings.

32-004.07C UR Committee: The utilization review committee must contain a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within their scope of practice and at least two clinical staff professionals (as defined in 471 NAC 32-001). The committee's reviews may not be conducted by any person whose primary interest in or responsibility to the program is financial or who is professionally involved in the care of the client whose case is being reviewed. At the Department's discretion, an alternative plan for facilities that do not have these resources readily available may be approved.

32-004.07D Basis of Review: The review must be based on -

1. The identification of the individual client by appropriate means to ensure confidentiality;
2. The identification of the supervising practitioner;
3. The date of admission;
4. The diagnosis and symptoms;
5. The supervising practitioner's plan of treatment; and
6. Other supporting materials (progress notes, test findings, consultations) the group may deem appropriate.
32-004.07E Contents of Report: The written report must contain -

1. An evaluation of treatment, progress, and prognosis based on -
   a. Appropriateness of the current level of care and treatment;
   b. Alternate levels of care and treatment available; and
   c. The effective and efficient utilization of services provided;
2. Verification that -
   a. Treatment provided is documented in the client's record;
   b. All entries in the client's record are signed by the person responsible for entry and dated. The supervising practitioner shall sign and date all of his/her orders; and
   c. All entries in the client's record are dated;
3. Recommendations for -
   a. Continued treatment;
   b. Alternate treatment/level of care; and
   c. Disapproval of continued treatment.
4. The date of the review;
5. The names of the program utilization review committee members; and
6. The date of the next review if continued treatment is recommended.

A copy of the admission review and the extended stay review must be attached to all claims for mental health services submitted to the Department for payment.

32-004.08 Limitations on Reimbursement of Allowable Costs: The following limitations apply to reimbursement of allowable costs:

1. Payment for a full day of day treatment is allowable when services are provided to a client for at least six hours per day.
2. Payment for a half day of day treatment is allowable when services are provided to a client for at least three hours per day but less than six hours per day. The rate for a half day of day treatment is limited to one half of the "full day" rate.
3. For programs that provide services for more than six hours, and up to twelve hours, payment can be prorated by the hour. For each additional hour of service beyond six, NMAP will pay an additional amount based on the cost-report.
32-004.08A  Documentation for Claims: The following documentation is required for all claims for day treatment/claims and must be kept in the client’s record:

1. A psychiatric assessment with mental status exam and diagnosis;
2. The treatment plan, if required (required at admission and every 30 days thereafter);
3. Orders by the supervising practitioner;
4. A complete family assessment;
5. Nurses’ notes; and
6. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-004.08B  Exception: Additional documentation from the client's medical record may be requested by the Department prior to considering authorization of payment.

32-004.08C  Costs Not Included in the Day Treatment Fee: The mandatory and optional services are considered to be part of the fee for day treatment services. The following charges can be reimbursed separately from the day treatment fee when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

32-004.09  Procedure Codes and Descriptions for Mental Health or Substance Abuse Day Treatment: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.
Treatment Foster Care Services: Treatment foster care services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and an Initial Diagnostic Interview documents the need for continued care of this level. Treatment foster care occurs in a foster home when specially trained foster parents are available at all times to provide consistent behavior management programs, therapeutic interventions, and render services under the direction of a supervising practitioner. Treatment foster care services must be community-based, family focused, culturally competent, and developmentally appropriate. Treatment is provided within a family environment with services that focus on improving the client/family's adjustment emotionally, behaviorally, socially, and educationally. To be eligible to receive treatment in a treatment foster care program, the client must participate in a HEALTH CHECK (EPSDT).

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Definitions: The following definitions and descriptions apply to treatment foster care services:

Agency Staff: Treatment foster care requires agency staff who are qualified, trained, and supported to implement the treatment model. Some treatment foster care initiatives have been undertaken in which one or a few staff with duties in other program areas assume responsibility for additional treatment foster care cases. Such arrangements tend to dilute the time, resources, and support available to the TFC Specialist and to the intensity and focus of the services provided. This does not constitute a true program of treatment foster care. A treatment foster care program must have an adequate number of staff to provide administration and direct services. See 471 NAC 32-001.04 for further staff requirements.

Children and Adolescents: Treatment foster care serves clients age 20 or younger whose special needs cannot be met in their own families and who require out-of-home care. In addition to providing treatment for specific problems or conditions, treatment foster care seeks to promote a permanent family living arrangement for the children and youth it serves.
Family Treatment: Treatment foster care programs also serve the families of the children and adolescents in their care. Treatment foster care programs seek to involve children and families in treatment-planning and decision making as members of the treatment team. They provide family services to children and their families when return home is planned, and actively seek to support and enhance children's relationships with their parents, siblings, and other family members throughout the period of placement regardless of the permanency goal unless such efforts are expressly and legally prohibited.

TFC Program: A program of treatment foster care is a coherent, integrated constellation of services specifically designed to provide treatment within the foster home setting. The term program implies a discreet organizational entity with clearly stated purposes and means of achieving them which are logically described and justified within the framework of a consistent treatment philosophy. As a program, treatment foster care is agency lead and team oriented.

Treatment: Treatment is the coordinated and planned provision of services and use of procedures designed to produce a planned outcome in a person's behavior, attitude, or general condition based on a thorough assessment of possible contributing factors. Treatment typically involves the teaching of adaptive, pro-social skills and responses which equip young persons and their families with the means to deal effectively with conditions or situations which have created the need for treatment. The term treatment presumes stated, measurable goals based on professional assessment, a set of written procedures for achieving them, and a process for assessing these results. Treatment accountability requires that goals and objectives be time limited and outcomes systematically monitored.

Treatment Foster Family: The treatment foster family is viewed as the primary treatment setting, with treatment parents trained and supported to implement the in-home portion of the treatment plan and promote the goals of permanency planning for children in their care. The treatment foster parents provide the main behavioral intervention and are available at all times. (At least one TFC parent per home must be considered a professional TFC parent whose time is dedicated to the TFC program.) While their role is essential to the model, treatment parents do not carry primary or exclusive responsibility for the design of treatment plans. This is a team function carried out under the clinical direction of qualified program staff.

32-005.02 Standards of Participation for Service Providers: The Nebraska Medical Assistance Program does not pay for care that is chronic or custodial. An agency that provides treatment foster care services shall meet the following standards for participation to ensure that payment is made only for active treatment:

1. The agency shall meet the standards in 471 NAC 32-001 and 471 NAC 32-005;
2. The treatment foster homes shall meet the minimum regulations for foster homes caring for children and be licensed through the Department (see 474 NAC 6-003) or approved by the placing agency;
3. The agency providing treatment foster care must be licensed as a Child Placing Agency (see 474 NAC 6-005);
4. The agency's records must be sufficient to permit the Department to determine the degree and intensity of treatment services furnished to the client/family;
5. The agency shall meet staffing requirements the Department finds necessary to carry out an active treatment program;
6. The program is designed to meet the developmental needs of persons age 20 and younger;
7. The program must provide for both planned and unplanned respite care services; and
8. The place of service must be the treatment foster family home.

32-005.02A Provider Agreement: A provider of treatment foster care (TFC) services shall complete a provider agreement, Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form along with a program plan to the Department for approval. The provider application and agreement must be renewed annually to coincide with the submittal of the cost report (see 471 NAC 32-005.09).

An outline of the information required in a program plan is available from the Division of Medicaid and Long-Term Care.

If an agency providing treatment foster care is licensed, certified, or accredited through another agency (Department of Health and Human Services, Division of Public Health, Joint Commission on Accreditation of Health Care Organizations (JCAHO), etc.), the provider shall maintain this and provide a current copy for verification.

Agencies providing treatment foster care must be appropriately licensed by the Department of Health and Human Services, Division of Public Health.

32-005.02B Annual Renewal/Update: The program will submit information with the provider agreement (see 471 NAC 32-005.02A) and update the information annually and whenever requested by the Division of Medicaid and Long-Term Care.

32-005.03 Guidelines for Use of the Treatment Foster Care Services for Children: A youth must have a diagnostic condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following general guidelines to determine when treatment foster care services for children are clinically necessary for a client:
1. Utilization of treatment foster care is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;

2. The child/youth's problem behaviors are persistent but can be managed with this moderate level of structure;

3. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.;

4. The child/youth has a history of previous problems due to ongoing inappropriate behaviors or psychiatric symptoms; or

5. Less restrictive treatment approaches have not been successful (see 42 CFR 441.152) or are deemed inappropriate by the supervising practitioner or treatment in a more restrictive setting has helped stabilize the client's behavior or psychiatric symptoms and they are ready to transition to a less restrictive level of care.

32-005.04 Staffing Standards for Participation

32-005.04A Staff Members: The following staff positions must be included in a treatment foster care program description. All staff must be operating within the scope of practice guidelines established by the Nebraska Department of Health and Human Services, Division of Public Health; alcohol and drug abuse counselors are licensed by HHS.

32-005.04A1 TFC Supervisor: The role of the TFC supervisor is to provide support and consultation to the treatment team and caseworker.

1. TFC supervisor responsibilities are -
   a. TFC Specialist supervision: The TFC supervisor will provide regular support and guidance to the caseworker through regular supervisory meetings and informal contact as needed. This TFC supervisor/specialist ratio must not exceed 1 to 6 and must be adjusted to accommodate for variables such as the severity of clients served or by the experience/qualifications of the casework staff.
   b. Treatment planning: The TFC supervisor is a member of the treatment team and shares the responsibilities of developing the plan. S/he also evaluates progress reports and updates.
   c. Crisis on-call: The TFC supervisor provides coordination and back-up to ensure that 24-hour on-call crisis intervention services are available and delivered to treatment families and client families.
   d. Other: May include but is not limited to any of the following:
      (1) Case management;
      (2) Case assessment;
      (3) Parent support and consultation;
      (4) Clinical and administrative supervision of staff;
      (5) Treatment parent recruitment;
      (6) Orientation;
      (7) Training and selection;
      (8) Youth intake and placement;
      (9) Record keeping;
      (10) Program evaluation;

2. TFC supervisor activities must be performed by a clinical staff member as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.
32-005.04A2 TFC Specialist: The TFC specialist is the practical leader of the treatment team and works in development of the treatment plan, supports and consults with the treatment families, client families, and other members of the treatment team. The TFC specialist also advocates for, coordinates, and links treatment families and client families to other services available in the community.

1. TFC specialist responsibilities:
   a. Treatment team:
      (1) Under the direction of the supervising practitioner and the TFC supervisor, the TFC specialist takes primary day-to-day responsibility for leadership of the treatment team. The TFC specialist organizes and manages all team meetings and team decision making. The TFC specialist takes an active role in identifying goals and coordinating treatment services provided to the youth.
      (2) The TFC specialist provides information and training to treatment team members who may not be familiar with the treatment foster care model. The TFC specialist prepares these individuals to work with treatment parents and client families in a manner which is supportive of their roles. The TFC specialist also prepares them to work with the team in a manner consistent with the treatment foster care practice and values.
   b. Treatment planning: The TFC specialist takes primary responsibility for the preparation of each client/family's written comprehensive treatment plan and the written updates of the plan. The TFC specialist seeks to inform and involve other team members in this process including treatment parents and the client family.
   c. Support/consultation to treatment parents:
      (1) The TFC specialist will provide regular support and technical assistance to the treatment parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. The fundamental components of technical assistance will be the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training, and problem solving during home visits.
(2) Other types of support/supervision include emotional support and relationship building, the sharing of information and general training to enhance professional development, assessment of the client's progress, observation/assessment of family interactions and stress, and assessment of safety issues. The TFC specialist will provide at least weekly contact by phone or in person with the treatment parent of each client family on his/her caseload. The TFC specialist will visit the treatment home to meet with at least one TFC parent no less than twice per month, or more often as is necessary.

d. Caseload: The number of client/families assigned to a TFC specialist is a function of: the size/density of the geographic area, the array of job responsibilities assigned, and the difficulty of the population served. The preferred maximum number of youth that may be assigned to a single TFC specialist is ten (individuals or siblings strips). (Flexibility within this standard is possible and will be considered on an individual program basis.)

e. Contact with client/family: The TFC specialist or other program staff shall regularly spend time alone with the client/families to allow them opportunity to communicate special concerns, to make direct assessment of their progress, and to monitor for potential abuse. The face-to-face contact must occur monthly, or more often based on the current needs of the client/family and the treatment parents and applies on an individual client/family basis.

f. Support/consultation of the client/families: The TFC specialist will seek support and enhance the client's relationships with his/her family during his/her time in treatment foster care. The TFC specialist will arrange and encourage regular contact and visitation as specified in the treatment plan. The TFC specialist will seek to include the client/family in treatment team meetings, treatment planning, and decision making, and will keep them informed of the client's progress.

g. Community liaison and advocacy: The TFC specialist will work with the treatment team to determine which community resources will help meet the needs of the client/families to meet the objectives of the treatment plan. The TFC specialist will advocate for and coordinate these services while providing technical assistance to the community agency.

h. Crisis on-call: The TFC specialist will work with other professionals on the team to coordinate 24-hour crisis coverage.

2. TFC specialist activities must be performed by a clinical staff member as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.
32-005.04A3 Other Members of the Agency Staff: These are recommended parts of the agency staff and several areas may be covered by one staff member:

1. Staff development and training;
2. Administrative support;
3. Consultants, including -
   a. Psychiatrist;
   b. Psychologist;
   c. Educational;
   d. Substance abuse;
   e. Sexual abuse;
   f. Family systems;
   g. Recreation therapist; and
   h. Legal; and
4. Respite care staff.

32-005.04A4 Supervising Practitioner: The role of the supervising practitioner is to support and supervise the treatment team in providing active treatment to the client/family.

1. The supervising practitioner must be a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice and must maintain this licensure in the state in which the program operates (see 471 NAC 32-001.04, Staffing Standards);
2. Supervising practitioner responsibilities:
   a. Treatment team participation: The supervising practitioner will provide regular support and guidance to the treatment team through team meetings;
   b. Treatment planning: The supervising practitioner helps in the development of a comprehensive treatment plan based on a thorough assessment for each client/family admitted to the program and input provided by the multidisciplinary team. S/he also participates in ongoing treatment planning and implementation for each client/family, as appropriate;
   c. Crisis on-call: The supervising practitioner provides consultation for on-call staff and foster parents. The supervising practitioner also helps coordinate emergency psychiatric hospitalizations when necessary and works with or is the admitting physician; and
   d. Client contact: The supervising practitioner will meet with the client/family as described in the treatment plan to assess the client's needs and monitor progress toward goals.
32-005.04B Staff Training and Support: All professional staff require preservice and ongoing professional development relevant to the treatment foster care model and to their individual job responsibilities. The staff training plan must be approved by the Department.

32-005.04B1 Crisis On-Call: The program shall provide on-call crisis intervention support to supplement that provided by the TFC supervisor and specialist to allow for 24-hour coverage and to avoid staff burnout.

32-005.04B2 Liability Insurance: Professional staff must be covered by liability insurance.

32-005.04B3 Legal Advocacy and Representation: The agency shall assist staff in obtaining legal advocacy and representation should the need arise in connection with the proper performance of their professional duties.

32-005.04B4 Respite Care: The program shall provide for planned and unplanned respite care for clients and treatment foster parents.

32-005.04C Treatment Parents: Treatment parents are members of the treatment team whose primary responsibility is to implement the specific strategies of the treatment plan. Their responsibilities also include providing parenting duties as outlined in state and agency regulations concerning foster parents. A treatment parent must be available 24 hours a day to respond to crisis or emergency situations. This may preclude one of the foster parents from working outside of the home. Treatment parents may not provide day care for children in their home.

32-005.04C1 Treatment Parent Responsibilities:

1. Foster role: Treatment duties encompass the basic parenting duties typically required of foster parents. These include, but are not limited to:
   a. Nutrition;
   b. Clothing;
   c. Shelter and physical care;
   d. Nurturance and acceptance;
   e. Supervision; and
   f. Transportation;
2. Treatment planning: The treatment parents shall assist the team in development of treatment plans for the client/family in their care. Treatment parents contribute vital input based upon their observations of the client/family in the natural environment of the treatment home;
3. Treatment implementation: The treatment parents have the primary responsibility for implementing the interventions identified in the treatment plan;
4. Treatment team meetings: The treatment parents shall work cooperatively with other team members and will attend team meetings, training sessions, and other meetings required by the program by the child's treatment plan;

5. Record keeping: The treatment parent shall systematically record information and document activities as required by the agency and the standards under which it operates. The treatment parent shall keep a systematic record of the client/family's behavior and progress in targeted areas on a daily basis (or more often as medically necessary);

6. Contact with child's family: The treatment parent shall assist the client in maintaining contact with his/her family and work actively to enhance and support these relationships as identified in the treatment plan;

7. Permanency planning assistance: The treatment parent shall assist with efforts specified by the treatment team to meet the child's permanency planning goals. These must include, but are not limited to -
   a. Emotional support;
   b. Advice;
   c. Demonstration of effective child behavior management and other therapeutic interventions to the child's family; and
   d. Support to the child and family during the initial period of post-treatment foster care placement.

8. Community relations: The treatment parent shall develop and maintain positive working relationships with service providers in the community such as schools, departments of recreation, social service agencies, and mental health programs and professionals;

9. Advocacy: The treatment parent shall work with other members of the treatment team to advocate on behalf of the child/family to achieve the goals identified in the treatment plan. This includes obtaining educational, vocational, medical, and other services needed to implement the treatment plan and to assure full access to and provision of public services to which the child is legally entitled; and

10. Notice of request for child move: Unless a move is required to protect the health and safety of the child or other treatment family members, the treatment parent shall provide at least 14 days' notice to program staff if requesting a child's removal from the home so as to allow for a planful and minimally disruptive transition.
32-005.04C2 Treatment Parent Selection: Treatment parents are selected in part on the basis of their acceptance of the program's treatment philosophy and their ability to practice or carry out this philosophy on a daily basis. They must be willing to accept the intense level of involvement and supervision provided by the treatment team in their treatment parenting functions and the impact of that involvement on their family life. Treatment parents must be willing to carry out all tasks specified in their treatment foster care program's job description including working directly and in a supportive fashion with the families of children placed in their care.

The program shall have a written policy explaining the procedures and criteria for treatment parent selection.

32-005.04C3 Treatment Parent Training: Treatment parent training must be a systematic, planned, and documented process which includes competency-based skill training and is not limited to the provision of information through didactic instruction. Training must be consistent and with the program's treatment philosophy and methods. It should prepare treatment parents to carry out their responsibilities as agents to the treatment process. The Treatment Parent and Respite Care staff training curriculum must be approved by the Department. The training must include the following components:

1. Preservice training: Prior to the placement of children in their homes, all treatment parents must complete the following training requirements:
   a. Basic: Treatment parents must satisfactorily complete the preservice training required of all foster parents; and
   b. Agency specific: 20 hours of agency specific primarily skill-based training consistent with the agency's treatment methodology and the service needs of the child.

2. In-service training: Each treatment parent must have a written educational plan, developed by the treatment foster care parent and their supervisors, on record which describes the content and objectives of in-service training. All treatment parents must complete a minimum of 12 hours of in-service training annually based on the specific training needs identified in the development plan and specific services treatment parents are required to provide. In-service training must emphasize skill development as well as knowledge acquisition and may include a variety of formats and procedures including in-home training provided by agency casework staff.

Respite care staff must be trained appropriately, as defined by the treatment program.
32-005.04C4 Treatment Parent Support: Treatment foster care programs are obligated to provide intensive support, technical assistance, and supervision to all treatment parents. This must include specific management and supervision services in addition to those listed below:

1. Information disclosure: All information the treatment foster care program receives concerning a client/family to be placed with a treatment family must be shared with and explained to the prospective TFC family prior to placement. Treatment parents have access to full disclosure of information concerning the child as well as the responsibility to maintain agency standards of confidentiality regarding such information. The information must include, but is not limited to -
   a. The child's strengths and assets;
   b. Potential problems and needs; and
   c. Initial intervention strategies for addressing these areas.

2. Respite: Respite care must be available at both planned and crisis times. The respite care provider must be trained according to the standards set by the treatment foster care program. The respite care providers must be informed of the client/family treatment plan and supervised in their implementation of the specific in-home strategies. There is no additional payment for respite care as this is a cost that must be included in the annual cost report.

3. Other support (the cost of these supports must be included in the cost report):
   a. Counseling: During their tenure as Treatment Families, treatment families must have access to counseling and therapeutic services arranged by the treatment foster care program for personal issues or problems caused or exacerbated by their work as treatment families. These issues may include marital stress or abuse of their own children by a client/family in their care.
   b. Peer support: The treatment foster care program shall facilitate the creation of support networks for treatment foster families (these may include formal groups, informal meetings, of "buddy" systems).
   c. Financial support: The treatment foster care program financial support to treatment parents must cover the cost of care associated with their treatment responsibilities and special needs of the client/family. The additional financial support given to treatment parents is directly related to the special skills, functions, and responsibilities required of them in fulfilling their roles as treatment parents. This is above and beyond the payment covering room, board, and care costs.
d. Damages and liability: The treatment foster care program shall have a written plan concerning compensation for damages done to a treatment family's property by client/families placed in their care. This plan must be provided as part of their preservice orientation. The agency shall provide liability coverage or assist the treatment family in obtaining it. Treatment foster parents are required to show documentation of coverage for home/apartment, vehicle (if appropriate), property, and liability insurance in addition to any coverage provided by or through the treatment foster care program.

e. Legal advocacy: The treatment foster care program shall assist treatment parents in obtaining legal advocacy for matters associated with the proper performance of their role as treatment parents.

32-005.05 Covered Services for Treatment Foster Care: Payment for treatment foster care services under the Nebraska Medical Assistance Program is limited to payment for necessary treatment services for diagnosable conditions. Medicaid shall pay for treatment provided to ameliorate or correct the diagnosed condition. Medicaid does not make payment for care that is primarily chronic or custodial in nature.

32-005.05A Coverage Criteria: The Department covers treatment foster care services when the following criteria are met. The services must be -

1. Active Treatment, which must be -
   a. Treatment provided under a treatment plan developed by the multidisciplinary treatment team based on a thorough evaluation of the client's restorative needs and potentialities, including the developmental needs of clients age 20 or younger. The multidisciplinary treatment team includes the supervising practitioner, the TFC specialist, the TFC parent, and other staff as necessary. The treatment plan must be retained in the client's record.

   The treatment plan must be completed within 14 days of the client's admission to treatment foster care. The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

   b. Reasonably expected to improve the client's medical condition or to determine a diagnosis. The treatment must, at a minimum, be designed to correct or ameliorate the client's symptoms to facilitate the movement of the client to a less restrictive environment within a reasonable period of time.

   c. Consistent with the requirements listed in 471 NAC 32-001.06.
2. Necessary Treatment Services, which must be an appropriate level of care based on documented evaluations, including a comprehensive diagnostic work up and team-ordered treatment.

3. Generally limited to one treatment child per home, or one sibling strip of up to two children. Programs may place more than one child or sibling strip of more than two only after specific review by the treatment team and prior authorization through the Division of Medicaid and Long-Term Care.

4. Therapeutic passes for client involved in TFC. Therapeutic passes are an essential part of the treatment for client/families involved in treatment foster care. Documentation of the client's continued need for treatment foster care must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client, per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

In the event that a client does require hospitalization while in treatment foster care, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-005.05B Special Treatment Procedures in Treatment Foster Care: If a child/adolescent needs behavior management and containment beyond time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in treatment foster care is limited to physical restraint. Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardian or the Department case manager must approve use of this procedure through informed consent and must be informed within 24 hours each time they are used.

Treatment Foster Care Programs must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and TFC parents and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.
**32-005.06 Intake Process:** Treatment foster care services are available to clients age 20 or younger when the condition needing care has been identified during a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, the need for this level of care has been identified in the Initial Diagnostic Interview and the client has a serious emotional disturbance as indicated by the following:

1. The youth must have a diagnosable condition under the current Diagnostics and Statistics Manual of the American Psychiatric Association, and that condition is seen as primarily responsible for the client's problems;
2. The condition must result in substantial functional limitations in two or more of the following areas:
   a. Self-care at an appropriate developmental level;
   b. Perception and expressive language;
   c. Learning;
   d. Self-direction, including behavioral controls, decision-making judgment, and value systems; and
   e. Capacity for living in a family environment.

**32-005.06A Intake Criteria:** The following criteria must be met for a client's admission to a treatment foster care program:

1. The need for treatment foster care must be identified on an Initial Diagnostic Interview based on the following criteria:
   a. The client must have sufficient need for active treatment at the time of intake to justify the expenditure of the client/family's and program's time, energy, and resources;
   b. Of all reasonable options for active treatment available to the client, active treatment in this program must be the best choice for expecting reasonable improvement in the client's condition;
2. The proposed or revised treatment plan must be the most efficient and appropriate use of the program to meet the client/family's particular needs;
3. The plan must address active and ongoing involvement of the family in care provision; and
4. The program is designed to meet the needs of clients age 20 and younger.

**32-005.07 Preadmission Authorization and Continued Stay Review**

**32-005.07A Preadmission Authorization:** For treatment foster care services to be covered by Medicaid, the need for admission to this level of care must be precertified by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice through an Initial Diagnostic Interview.

**32-005.07B Prior Authorization:** Treatment Foster Care Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.
32-005.07C Continued Stay Review/Utilization Review: Each program is responsible for establishing a utilization review plan and procedure. A site visit by Medicaid and/or Health and Human Services staff for purpose of utilization review may be required for further clarification and review for payment (see 471 NAC 32-001.11).

32-005.08 Documentation

32-005.08A Treatment Plan: The treatment plan must be developed within the first 14 days after the client's admission to the program. The plan must be reviewed by the multi-disciplinary team at least every 30 days thereafter.

The multi-disciplinary treatment team consists of the treatment parent, the TFC specialist, the supervising practitioner, and other persons as necessary (parents, Department case manager).

Copies of the treatment plan must be retained in the client’s record.

The treatment plan retained in the client’s record must include -

1. The client's name;
2. The client's Medicaid number;
3. An indication if the client is a Department ward;
4. Date of the HEALTH CHECK during which the condition was disclosed;
5. The name of the referring physician (EPSDT);
6. The client's gender;
7. The client's age;
8. An indication if this is an initial or updated document;
9. The date of the initial diagnostic interview;
10. The date of the last report;
11. The date of this report;
12. Current active symptoms and/or functional impairments;
13. Date of onset of current acute condition;
14. An indication of whether this service was court-ordered (a copy of the court order must be attached);
15. An indication of whether psychological testing and/or a substance abuse evaluation has been completed (a copy of the results must be included);
16. Associated medical, legal, social, educational, occupational, or other problems;
17. Consultations;
18. Diagnoses;
19. Progress or complications since last report, including the client/family's participation in treatment;
20. Short term goals;
21. Long term goals;
22. Therapeutic interventions prescribed by the treatment team (frequency and by whom) including:
   a. Family therapy, training, and visits;
   b. Behavioral management;
   c. Individual counseling; and
   d. Group counseling;
23. Medication prescribed, physician monitoring medication, frequency, and dose;
24. The estimated length of stay at this level of care;
25. Placement and discharge plan;
26. Prognosis and brief explanation;
27. The provider's name; and
28. The provider's Medicaid number.

The treatment plan must be signed by the supervising practitioner.

32-005.08B Documentation in the Client's Clinical Record: Each client/family's clinical record must contain the following information:

1. The treatment plan;
2. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the progress notes must be recorded at least daily. The progress notes must contain a concise assessment of the client/family's progress and recommendations for revising the treatment plan, as indicated by the client/family's condition, and discharge planning;
3. The program's utilization review committee's abstract or summary;
4. The discharge summary; and
5. Other documentation as required in 471 NAC 32-001.05.

32-005.09 Procedure Codes and Descriptions for Treatment Foster Care: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-005.10 Costs Not Included in the Treatment Foster Care Per Diem: The mandatory, family therapy and optional services are considered to be part of the per diem for TFC. The following charges can be reimbursed separately from the TFC per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician or psychologist other than the supervising practitioner;
4. Treatment services for a physical injury or illness provided by other professionals; and
5. Other necessary treatment interventions including individual or group therapy and day treatment services.
If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

The TFC per diem does not include room and board costs.

32-005.11 Services Not Covered: Payment is not available for treatment foster care for clients if:

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-004.04, Services Provided Outside Nebraska;
2. Whose needs are social or educational and may be met through a less structural program;
3. Whose primary diagnosis and functional impairment is so severe in nature and whose condition is not stable enough to allow them to participate in and benefit from the program; or
4. Whose behavior may be very disruptive and/or harmful to themselves, other program participants, or staff members.

32-005.12 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for Treatment Foster Care Services. Please refer to 471 NAC 32-001.08 and 32-001.09.
32-006 Treatment Group Home

32-006.01 Introduction and Legal Basis: Treatment group home services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care has been identified as part of an Initial Diagnostic Interview. Treatment group homes are non-hospital based treatment services that are community-based, family-centered, and culturally competent.

Treatment group home services for children and adolescents covered by Medicaid include treatment group home services for children age 20 and younger who are eligible for Medicaid. The policy in this section also covers children age 18 or younger who are wards of the Department.

Treatment group home services must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice for reduction of physical or mental disability, to restore a recipient to a better level of functioning, and to facilitate discharge to a less restrictive level of care.

32-006.02 Treatment Group Home Services for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be developmentally appropriate, family-centered, culturally competent and community based. It must directly involve the immediate family in all phases of treatment and discharge planning. Family may include biological, step, foster, or adoptive parents, sibling or half sibling, and extended family members as appropriate.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.
Care must involve a representative from the appropriate home community service providers. This may include such areas as education, social services, law enforcement, religion, medical, and mental health professionals. NMAP will cover more restrictive levels of care only when all other resources have been explored and deemed to be inappropriate. If hospital-based inpatient care is deemed appropriate, see 471 NAC 32-008. If psychiatric residential treatment services are deemed appropriate, see 471 NAC 32-007.

To ensure a less institutional setting, each location where children are housed can serve no more than 2 units of up to 20 beds. Facilities may have up to two crisis intervention beds per unit (see 32-003 Treatment Crisis Intervention) and the facility must provide a home-like atmosphere.

32-006.03 Standards for Participation for Treatment Group Home Services

32-006.03A Provider Agreement: A provider of treatment group home services shall complete Form MC-19 or MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. The Department is the sole determiner of which facilities are approved for participation in this program. The facility will be advised in writing when its participation is approved.

The provider shall submit the following with Form MC-19 or MC-20:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
   a. A complete description of how the family-centered requirement will be met, including a complete description of any home-based family therapy services;
   b. A complete description of how the community-based requirement will be met;
   c. A description of each available service;
   d. A list of treatment modalities available and the capacity for individualized treatment planning;
   e. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   f. A schedule covering the total number of hours that the program operates;
   g. The Department approved cost reporting document; and
   h. The target population.

2. Facility/Program Changes: A treatment group home facility shall report to the HHS Resource Development and Support Unit and to the Division of Medicaid and Long-Term Care any major change in its program and/or facilities, before the change is made. The HHS Resource Development and Support Unit will determine whether the license must be modified or reissued. Any change in the capacity of a licensed facility requires that a license be reissued showing the number of youth who can be cared for under the new plan. The Division of Medicaid and Long-Term Care will determine if the facility maintains appropriate therapeutic programming for NMAP reimbursement.
3. Confirmation that the staffing standards in 471 NAC 32-006.03E are met.

4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation.

32-006.03B Place of Service: Treatment group home services may be provided in the following locations when the requirements in this section have been met:

1. A community-based facility in operation prior to 7-1-94, as a treatment group facility. (These facilities may apply for an exception to the unit/bed maximum. The Department is the sole determiner of eligibility for this exception.)

2. A residential type community-based treatment facility appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; or

3. A hospital that is licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, is accredited by the Joint Commission on Accreditation of Health-Care Organizations (JCAHO) or the American Osteopathic Association (AOA), meets the requirements for participation in Medicare, and has a utilization review plan applicable to all Medicaid clients in effect.

32-006.03B1 Facility and Program Requirements: In order to be approved as a provider of Treatment Group Home Services, the program must insure that the following requirements are met:

1. Adequate access to recreational facilities for both indoor and outdoor activities, commensurate with the size and scope of the program. (This may be provided on-site or through contract);

2. Separation of the treatment group home program from inpatient hospital operations, including laboratory, radiology, surgery, patient rooms, dining areas, patient lounges, etc.;

3. The doors to the unit and to the outside may be locked from the outside to allow for safety, but they must be unlocked or easily unlocked from the inside;

4. Kitchen and laundry facilities easily accessible to the unit;

5. Staff offices must be located on the unit;

6. Secure storage for medications and clinical charts must be on the unit;

7. A general living or lounge area must be on the unit;

8. A home-like atmosphere;

9. Program is staffed by awake personnel 24 hours per day; and

10. Other requirements as listed in this chapter.
32-006.03C Licensure: The treatment group home facility must -

1. Be in compliance with all applicable federal, state, and local laws;
2. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
3. Meet the definition of a treatment group home facility as stated in this section;
4. Maintain documentation in each client's treatment record that provides a full and complete picture of the nature and quality of all services provided (see 471 NAC 32-006.07);
5. Have the capacity to meet the needs of the individual Medicaid client either through employment of or contracts with appropriate staff;
6. Be licensed under the minimum regulations for child caring agencies if not a hospital-based facility. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. (See 474 NAC 6-005, Licensing Group Homes and Child Caring and Placing Agencies.)

32-006.03D Accreditation: The licensed treatment group home must have -

1. Be accredited by JCAHO, CARF, COA or AOA; or
2. Include a copy of the accreditation certificate with the initial and updated enrollment materials and forward a copy of all survey visit reports and provider responses.

Facilities accredited by these accrediting bodies are eligible to receive reimbursement for treatment and maintenance (room and board) costs and must maintain accreditation in order to qualify as a treatment group home provider. Treatment and maintenance costs are reimbursed as a per diem rate. See NMAP Fee Schedule, (Appendix 471-000-532).

Interpretive Note: Agencies that have applied for accreditation may be enrolled on a provisional status and receive reimbursement for treatment services only.
32-006.03E Staffing Standards for Participation: A treatment group home for children shall meet the following standards to participate in NMAP:

1. The facility's staff must include:
   a. An executive director who has sufficient background and experience to administer a treatment program;
   b. A program director who meets the requirements of a clinical staff person in 471 NAC 32-001.04 and is acting within his/her scope of practice, with two years of professional experience in the treatment of children and adolescents with mental illnesses or emotional disturbances;
   c. Clinical staff professionals (who meet the requirements of a clinical staff person in 471 NAC 32-001.04) who provide family assessments and psychotherapy, including face-to-face individual, family, and group therapy, who are supervised by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice;
   d. Child care staff who are age 21 or older and have specialized training and experience sufficient to equip them for their duties and are under the supervision of the program director. 67% of child care staff must have a bachelor's degree or four years of experience in the human services field;
   e. Supervisory staff will meet the standards outlined in 471 NAC 32-001.04 and have four years experience in a related field;
   f. Training must be approved by the Department and must meet the minimum standards for pre-service and on-going training in licensing requirements;
   g. A supervising practitioner who is a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice;
   h. Each facility shall show by employment records or on a contractual basis the ability to provide the needed services as indicated by the scope of the program, including necessary medical/psychiatric evaluations, and access to emergency care. The clinical services of a psychologist, psychiatrist, and physician may be obtained on a consultation basis; and
   i. Educators, when on-site education is provided. Services must be provided in accordance with applicable state and federal laws. NMAP does not make payment for educational services (see 471 NAC 32-006.05J);

2. Volunteer services may be used to augment and assist other staff in carrying out program or treatment plans. Volunteers who work directly with youth must receive orientation training regarding the program, staff, and children of the center and the functions that volunteers can perform. However, the services performed by a volunteer cannot be substituted for necessary medical/psychiatric and therapeutic patient/staff ratios;
3. Staff must be mentally and physically capable of performing assigned duties and demonstrate basic professional competencies as required by the job description. Every staff member shall have an annual physical examination and obtain a statement that no medical condition exists that may interfere with his/her ability to perform assigned duties. This is addressed in policy governing licensure regulations. All applicable state, federal, and local laws must be followed;

4. All program personnel having access to clients, including full-time, part-time, paid, volunteer, or contract, must be checked through the Central Registry, Adult Protective Services Registry, and the motor vehicle records. A criminal check must also be done through a law enforcement agency. A person whose name appears on any of the above registers because of behavior or activities that might be dangerous to clients must not have access to clients;

5. The ratio of professional staff to children is dependent on the needs of the children and commensurate with the size and scope of the program, however -
   a. The minimum ratio of Master's level therapists providing direct face-to-face therapy services to children and families must be 1:12;
   b. The supervising practitioner must be available to spend approximately 45 minutes per month or more often as clinically necessary, per client, in the facility as a minimum. This includes face-to-face time with the client, treatment plan reviews, and supervision;
   c. There must be sufficient supervising practitioner consultation hours on a regular basis to meet the requirements for active treatment. Youth at this level of care must be assessed by the supervising practitioner a minimum of once a month, or more frequently if medically necessary;

6. The ratio of child care staff to children during prime time hours is dependent on the needs of the children and the requirements of the individualized treatment plans. The ratio of staff to children must be commensurate with the size and scope of the program; however, minimum ratio is 1:6. This may be increased depending on the intensity of the program and the children's needs;

7. The ratio of child care awake staff during sleeping and non-prime hours is dependent on the needs of the children and must be commensurate with the size and scope of the program; however, the minimum ratio is 1:8. This may be increased depending on the intensity of the program and the individual child's needs.

8. The facility must be able to call back child care staff to provide staff and client safety in crisis situations.

9. If the facility has a level program that requires intense observation for admissions, the direct care staff to youth ratio will need to be more intense during that observation period.

10. Access to emergency services such as additional supervision and physician psychologist services must be available on a 24-hour basis.
32-006.03F Service Standards for Participation for Treatment Group Home Facilities: Treatment group home facilities shall -

1. Make every effort to keep the child in contact, where appropriate and possible, with the child's family and relatives, when reunification/reconciliation is the plan and maintain documentation of these activities;

2. Directly involve the immediate family in all phases of treatment and discharge planning. Family may include biological, step, foster, or adoptive parents, sibling or half sibling, and extended family members as appropriate. For wards of the Department, the case manager must be included in all phases of assessment, treatment planning, evaluation of services, and discharge/after care arrangements;

3. Provide a total of 21 hours of scheduled treatment interventions each week. These must include, but are not limited to:
   a. Group psychotherapy by a practitioner operating within their scope of practice;
   b. Individual therapy by a practitioner operating within their scope of practice;
   c. Family intervention (one hour per week minimum); and
   d. Other approved group or individual therapeutic activities.

4. Provide or arrange for face-to-face family therapy a minimum of twice a month. Depending on the child's needs, this may include reunification/reconciliation therapy and may also include biological, step, foster or adoptive families, psychological parents, and/or extended family (this is included in the 21 hours per week);

5. Provide the following mandatory services -
   a. Clinically Necessary Nursing Services: Medical services directed by a Qualified Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document approved by the supervising practitioner.
   b. Clinically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a licensed psychologist acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
   c. Clinically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse, or by a staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a Medication Aide.
d. Clinically Necessary Dietary Services: The meal services provided must be supervised by a registered dietitian, based on the client's individualized diet needs. Programs may contract for these services through an outside licensed certified facility.

e. Transition and discharge planning must meet the requirements of 471 NAC 32-001.07A.

6. Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy:

a. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
   (1) Recreational Therapy;
   (2) Speech Therapy;
   (3) Occupational Therapy;
   (4) Vocational Skills Therapy;
   (5) Self-Care Services: Services supervised by a staff person who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.

b. Psychoeducational Services: Therapeutic psychoeducational services may be provided as part of a total program. Therapeutic psychoeducational services must be provided by teachers specially trained to work with child and adolescent experiencing mental health or substance abuse problems. These services may meet some strictly educational requirements, but must also include the therapeutic component. Professionals providing these services must be appropriately licensed and certified for the scope of practice.

c. Social Work Services by a Bachelor's Level Social Worker: Case management social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment;

d. Crisis Intervention (may be provided in the client's home);

e. Social Skills Building;

f. Life Survival Skills;

g. Substance abuse prevention, intervention, or treatment by an appropriately licensed alcohol and drug counselor.
7. Provide appropriate conferences involving the client's interdisciplinary treatment team, the parents, the referring agency, and the child, to review the case status and progress at least every month. This does not substitute for documentation requirements. The need for conferences with interested parties is indicated by the individual child's circumstances and needs. For wards of the Department, this need will be jointly determined with the Department case manager;

8. Provide a multi-disciplinary team progress report to the referring agency, the parents, and the legal guardian every month for the purpose of service coordination. This progress report must include a summary of the work done, the progress made by each multi-disciplinary team area, since the last report; plus treatment plans for the next reporting period. For wards of the Department, monthly reports must be provided to the Division of Children and Family Services case manager. The documentation from the Monthly Treatment Plan review may serve this purpose.

9. The services of specialists in the fields of medicine, psychiatry, clinical psychology, and education must be used as needed. The costs of these services must be included in the total cost of care and cannot be billed separately.

10. Allow for more than one type of activity to be scheduled at one time allowing for specialized and individualized treatment planning.
32-006.03G Annual Update Renewal: The treatment group home shall submit the following information with the provider application and agreement, and update/renew the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
   a. A complete description of how the family-centered requirement will be met, including a complete description of any home-based family therapy services;
   b. A complete description of how the community-based requirement will be met;
   c. A description of each available service;
   d. A list of treatment modalities available and the capacity for individualized treatment planning;
   e. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   f. A schedule covering the total number of hours that the program operates;
   g. The cost report; and
   h. The target population.
2. Confirmation that the staffing standards are met;
3. A copy of child caring agency licensure certificate; and
4. A copy of accreditation from JCAHO, CARF, COA, or AOA.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-006.04 Covered Services: Medicaid limits payment for treatment group home services to those services for medically necessary primary psychiatric diagnoses. Medicaid covers treatment group home services when the services are medically necessary and provide active treatment.

32-006.04A Pre-Admission Authorization: For treatment group home services to be covered by Medicaid, the admission must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within their scope of practice through an Initial Diagnostic Interview and prior authorized through the Division of Medicaid and Long-Term Care or its designee. Consent for treatment for wards of the Department must be obtained from the case manager or supervisor.
32-006.04B Guidelines for Use of the Treatment Group Home Services for Children: A youth must have a diagnostic condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following general guidelines to determine when treatment group home services for children are clinically necessary for a client:

1. The child/youth requires 24-hour awake supervision;
2. Utilization of treatment group home care is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
3. The child/youth’s problem behaviors are persistent, may be unpredictable, and may jeopardize the health or safety of the client and/or others, but can be managed with this moderate level of structure;
4. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.;
5. The child/youth has a history of previous problems due to ongoing inappropriate behaviors or psychiatric symptoms; or
6. Less restrictive treatment approaches have not been successful (see 42 CFR 441.152) or are deemed inappropriate by the supervising practitioner or treatment in a more restrictive setting has helped stabilize the client's behavior or psychiatric symptoms and they are ready to transition to a less restrictive level of care.

32-006.04C Therapeutic Passes for Clients Involved in Treatment Group Home Services: Therapeutic passes are an essential part of the treatment for client/families involved in treatment group home services. Documentation of the client's continued need for treatment group home services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.
32-006.04D Vacations: If a treatment group home program takes the clients on a "vacation," NMAP will reimburse for those days under the following conditions:

1. The trip is prior authorized by the Division of Medicaid and Long-Term Care or its designee;
2. There is a clear statement of goals and objectives for the client's participation in the trip;
3. At least 50% of the scheduled treatment interventions must occur during the "vacation";
4. A clinical staff person must accompany the "vacation" trip; and
5. The "vacation" must be included in the treatment program.

NMAP will reimburse for up to seven "vacation" days per year for clients in treatment group home services.

32-006.05 Additional Requirements

32-006.05A Work Experience: When a treatment group home has a work program, it must:

1. Provide work experience that is appropriate to the developmental age and abilities of the child;
2. Differentiate between the chores that children are expected to perform as their share in the process of living together, specific work assignments available to children as a means of earning money, and jobs performed in or out of the center to gain vocational training;
3. Give children some choice in their work experiences and offer change from routine duties to provide a variety of experiences;
4. Not interfere with the child's time for school, study periods, play, chores, sleep, normal community activities, visits with the child's family, or individual, group, or family therapy; Clients may not be solely responsible for any major phase of the center's operation or maintenance, such as cooking, laundering, housekeeping, farming, or repairing;
5. Comply with all state and federal labor laws.

32-006.05B Solicitation of Funds: A treatment group home may not use a child for advertising, soliciting funds, or in any way that may cause harm or embarrassment to the child or the child's family. Written consent of the parent or guardian must be obtained before the treatment group home uses a child's picture, person, or name in any form of written, visual, or verbal communication. Before obtaining consent, the treatment group home shall advise the parent or guardian of the purpose for which it intends to use the child's picture, person, or name, and of the times and places when and where this use would occur. Photos of the Department state wards cannot be used for these purposes.
32-006.05C Special Treatment Procedures: Special treatment procedures in treatment group homes are limited to physical restraint. Locked time out (LTO), mechanical restraints, and pressure point tactics are not allowed. For wards of the Department, the case manager must approve use of physical restraints and must be informed within 24 hours each time they are used. Guardians and parents of non-wards must give informed consent and be informed of the use of physical restraints.

Facilities must meet the following standards regarding physical restraints:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of physical restraints;
2. Physical restraints may be used only when a youth's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The youth's treatment plan must address the use of physical restraints and have a clear plan to decrease the behavior requiring physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the use of restraints, and subsequent processing must be documented in the clinical record.

32-006.05D Medical Care: The center shall ensure that the following medical care is provided for each child:

1. Each child must receive a medical examination immediately before or at the time of admission;
2. Each child must have current immunizations as required by the Nebraska Department of Health and Human Services;
3. The treatment group home shall arrange with a physician and a psychiatrist for the medical and psychiatric care of the clients;
4. Each child must have a medical examination/HEALTH CHECK (EPSDT) screen annually as allowed in 471 NAC 33-000 ff.;
5. The treatment group home shall inform staff members of what medical care, including first aid, may be given by staff without specific physician orders. Staff must be instructed on how to obtain further medical care and how to handle emergency cases. The center shall ensure that-
   a. Staff members on duty must have satisfactorily completed current first aid and cardiopulmonary resuscitation training and have on file at the treatment group home a certificate of satisfactory completion as required by licensure regulations of the Department of Health and Human Services, Division of Public Health;
   b. Each staff member must be able to recognize the common symptoms of illnesses in children and to note any marked physical defects of children; and
   c. A sterile clinical thermometer, a complete first aid kit, and clearly posted emergency phone numbers must be available, according to licensure regulations of the Department of Health and Human Services.
32-006.05E Hospital Admissions: The treatment group home shall make arrangements for the emergency admission of children from the center in case of serious illness, emergency, or psychiatric crisis. For wards of the Department, the case manager or the case manager's supervisor must give permission for admission.

In the event that a client does require hospitalization while in a treatment group home, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-006.05F Hospitalization or Death Reports: The treatment group home shall report any accident or illness requiring hospitalization to the parents or guardian immediately. The treatment group home shall immediately report any death to the parents or guardian, the Department, a law enforcement agency, and the county coroner. If the child is a Department ward, see 390 NAC 11-002.01D.

32-006.05G Dental Care: Each child must have an annual dental examination. If a child has not had a dental exam in the twelve months before admission, an examination must occur within 90 days following admission. See 471 NAC 6-000 and 33-000 and 474 NAC 6-005.26F.

32-006.05H General Health: The treatment group home shall ensure the following:

1. Each child must have enough sleep for the child's age and physical and emotional condition at regular and reasonable hours, and under conditions conducive to rest. While children are asleep, at least one staff member must be within hearing distance;
2. Children must be encouraged and helped to keep themselves clean;
3. Bathing and toilet facilities must be properly maintained and kept clean;
4. Each child must have a toothbrush, comb, an adequate supply of towels and washcloths, and personal toilet articles;
5. Menus must provide for a varied diet that meets a child's daily nutritional requirements;
6. Each child must have clothing for the child's exclusive use. The clothing must be comfortable and appropriate for the current weather conditions; and
7. The treatment group home must provide safe, age-appropriate equipment for indoor and outdoor play.

See 471 NAC 33-000.
32-006.05J Education: Educational services, when required by law, must be available. Educational services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the Department.

32-006.05K Religious Education: Children must be provided with an opportunity to receive instruction in their religion. No child may be required to attend religious services or to receive religious instructions if the child chooses not to attend the services or receive instruction.

32-006.05L Discipline: Discipline must be therapeutic and remedial rather than punitive. Corporal punishment, verbal abuse, and derogatory remarks about the child, the child's family, religion, or cultural background are prohibited. A child may not be slapped, punched, spanked, shaken, pinched, or struck with an object by any staff of the center. Only staff members of the treatment group home may discipline children (see 474 NAC 6-005.26K).

32-006.05M Transition and Discharge Planning: Whenever a child or adolescent is transferred from one setting to another, transition and discharge planning must be performed and be documented, beginning at the time of admission (see 471 NAC 32-001.07A and 474 NAC 6-005.27H).

Facilities must meet the following standards regarding transition and discharge planning:

1. Transition and discharge planning must be based on the multidisciplinary treatment plan designed to achieve the client's transition into and discharge from treatment group home treatment status to a less restrictive level of care at the earliest possible time;
2. Transition and discharge planning must address the client's need for ongoing treatment to maintain treatment gains, continuing education and support for normal physical and mental development following discharge;
3. Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;
4. The treatment group home treatment facility shall arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into and following the client's discharge;
5. A written transition and discharge summary must be provided as part of the medical record; and
6. The child's parents (and the caseworker if the child is a ward) must be included in all phases of transition and discharge planning. This participation must be clearly documented in the client's record.
32-006.05N Notification of Runaway Children: See 390 NAC 7-001.05.

32-006.05P Interstate Compact on the Placement of Children: The center shall comply with the interstate compact on the placement of children. (See 474 NAC 6-005.)

32-006.05Q Medications: The treatment group home may possess a limited quantity of nonprescription medications and administer them under the supervision of designated staff. The treatment group home must follow all applicable regulations through the Department of Health and Human Services, Division of Public Health for storing and administering medications.

The treatment group home shall have written policies governing the use of psychotropic medications. Parents and the guardian of a client who receives psychotropic medication must be informed of the benefits, risks, side effects, and potential effects of medications. A parent and legal guardian's written informed consent for use of the medication must be obtained before giving the medication and filed in the client's record. If the client is a state ward, informed consent must be given by the Department case manager.

A child's medication regime must be reviewed by the prescribing physician at least every seven days for the first 30 days following the initiation of a new medication and at least every 30 days thereafter.

32-006.06 Individualized Treatment: The requirements of 42 CFR 441, Subpart D, must be met. To be covered by NMAP, services must include -

1. Program philosophy: Treatment Group Home facilities must provide family-centered, community-based, developmentally appropriate services under the direction of a supervising practitioner.
   a. These services must be able to meet the special needs of families with emotionally disturbed children. Families must be involved in all phases of treatment and discharge planning. For wards of the Department, the Department case manager must also be involved in all phases of treatment and discharge planning.
   b. The program intensity must be such that direct care staff, the youth in treatment, and/or the youth's family have access to professional staff on an "as needed" basis, determined by the child's condition.
2. **Active treatment**, which must be -
   a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The initial treatment plan must be developed within 14 days of the client's admission. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team, the parents and/or the parents' advocate, the referring agency and the child.
   
The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   
   b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
   c. In compliance with 471 NAC 32-001.06, Active Treatment.

3. **Medically necessary services**, which must be an appropriate level of care based on the documented Initial Diagnostic Interview by the supervising practitioner either prior to admission or immediately following admission.

32-006.07 **Documentation in the Client's Clinical Record**: The treatment group home must maintain accurate records indicating the degree and intensity of the treatment provided to clients who receive services in the treatment group home facility. For treatment group home services, clinical records must stress the clinical components of the care, including history of findings and treatment provided for the condition for which the client is in the facility. The record must include the requirements stated in 471 NAC 32-001.05, and -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the diagnoses;
3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;
4. The medical/psychiatric history, which contains a record of the initial diagnostic interview and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. Complete psychological evaluation when indicated;
6. Complete neurological examination, when indicated;
7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment, and transition and discharge planning;

8. A thorough family assessment;

9. Reports of consultations, electroencephalograms, dental records, and special studies;

10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;

11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities.

12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.

13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and

14. The client's response to therapeutic leave days recommended by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

All documents from the client's clinical record submitted to the Department must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

32-006.08 Utilization Review: All facilities must provide utilization review.

32-006.09 Documentation for Claims: The following documentation is required for all claims for treatment group home services. This requirement may be waived at the Department's discretion. The facility will be notified in writing if that occurs:

1. Initial Diagnostic Interview;
2. The treatment plan;
3. Orders by the supervising practitioner; and
4. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-006.09A Exception: Additional documentation from the client's clinical record may be requested by the Department prior to considering authorization of payment.
32-006.10 Procedure Code and Description for Treatment Group Home Services: HCPCS/CPT codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-006.11 Costs Not Included in the Treatment Group Home Per Diem: The mandatory and optional services are considered to be part of the per diem for treatment services. The following charges can be reimbursed separately from the treatment group home per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

32-006.12 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for Treatment Group Home Services. See 471 NAC 32-001.08 and 471 NAC 32-001.09.
32-007 Residential Treatment Services for Children/Adolescents

32-007.01 Introduction: Residential treatment services are available to clients age 20 or younger when the client participates in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for care at this level has been identified on the Initial Diagnostic Interview.

Residential treatment services must be family-centered, culturally competent, community based, and developmentally appropriate.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Residential treatment services for children covered by Medicaid include residential treatment for children age 20 and younger who are eligible for Medicaid. These regulations also cover children age 18 or younger who are wards of the Department.

Residential treatment services must be provided under the direction of a supervising practitioner as designated in 471 NAC 32-001.06

32-007.02 Residential Treatment for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be family-centered, community-based, culturally competent, and developmentally appropriate. Medicaid will cover more restrictive levels of care only when all other resources have been explored and deemed to be inappropriate. If hospital-based inpatient care is deemed appropriate, see 471 NAC 32-008.

Residential treatment center services are clinically necessary services provided to a client who requires professional care and highly structured 24-hour awake care at a greater intensity than that available at the treatment group home and foster home levels.
In keeping with the philosophy that children are better served in more family-like settings, the total number of approved beds for a residential treatment center will not exceed two units of up to 20 beds each, and the center must provide a home-like atmosphere commensurate with the size and scope of the program. Exception: A state owned and operated residential treatment center may exceed two units provided that each unit has no more than 20 beds each. When a state owned and operated residential treatment center exceeds two 20 bed units, children may be placed there for treatment only if all other in state residential treatment center providers have declined to serve the child within a reasonable period of time. This exception shall expire two years after the effective date of the exception.

32-007.03 Standards for Participation for Residential Treatment Centers

32-007.03A Provider Agreement: A provider of residential treatment center services shall complete Form MC-19 or Form MC-20, “Medical Assistance Provider Agreement,” and submit the completed form to the Department for approval. The Department is the sole determiner of which centers are approved for participation in this program. The facility will be advised in writing when its participation is approved.

The provider shall submit the following with Form MC-19 or Form MC-20:

1. A written overview of the program’s philosophy and objectives of treating children and youth including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. The Department approved cost reporting document; and
   f. The target population.
2. Facility/Program Changes: A residential treatment facility shall report to the HHS Licensing Unit and to the Division of Medicaid and Long-Term Care any major changes in its program and/or facilities, before the change is made. The HHS Licensing Unit will determine whether the license must be modified or reissued. Any change in the capacity of a licensed facility requires that a license be reissued showing the number of youth who can be cared for under the new plan. The Division of Medicaid and Long-Term Care will determine if the facility maintains appropriate therapeutic programming for NMAP.
3. Confirmation that the staffing standards in 471 NAC 32-007.04D are met.
4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. Licensure as a child caring agency is not required for hospital-based services.
5. Copy of JCAHO, CARF, AOA, or COA accreditation certificate.
32-007.03 Standards for Participation for Residential Treatment Centers

32-007.03A Provider Agreement: A provider of residential treatment center services shall complete Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. The Department is the sole determiner of which centers are approved for participation in this program. The facility will be advised in writing when its participation is approved.

The provider shall submit the following with Form MC-19 or Form MC-20:

1. A written overview of the program’s philosophy and objectives of treating children and youth including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. The Department approved cost reporting document; and
   f. The target population.

2. Facility/Program Changes: A residential treatment facility shall report to the HHS Licensing Unit and to the Medicaid Division any major changes in its program and/or facilities, before the change is made. The HHS Licensing Unit will determine whether the license must be modified or reissued. Any change in the capacity of a licensed facility requires that a license be reissued showing the number of youth who can be cared for under the new plan. The Medicaid Division will determine if the facility maintains appropriate therapeutic programming for NMAP.

3. Confirmation that the staffing standards in 471 NAC 32-007.04D are met.

4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. Licensure as a child caring agency is not required for hospital-based services.

5. Copy of JCAHO, CARF, AOA, or COA accreditation certificate.
32-007.03B  Place of Service: Residential treatment services may be provided in the following locations when the requirements listed in 471 NAC 32-007.04B have been met:

1. A residential type community-based treatment facility appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; or
2. A hospital that is licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, is accredited by the Joint Commission on Accreditation of Health-Care Organizations (JCAHO) or the American Osteopathic Association (AOA), meets the requirements for participation in Medicare, and has a utilization review plan applicable to all Medicaid clients in effect.

32-007.03B1  Facility Requirements: In order to be approved as a provider of Residential Treatment Services, the program must insure that the following requirements are met:

1. Adequate access to recreational facilities for both indoor and outdoor activities, commensurate with the size and scope of the program. (This may be provided on-site or through contract);
2. Separation of the treatment group home program from inpatient hospital operations, including laboratory, radiology, surgery, patient rooms, dining areas, patient lounges, etc.;
3. The doors to the unit and to the outside may be locked from the outside to allow for safety, but they must be unlocked or easily unlocked from the inside;
4. Kitchen and laundry facilities easily accessible to the unit;
5. Staff offices must be located on the unit;
6. Secure storage for medications and clinical charts must be on the unit;
7. A general living or lounge area must be on the unit;
8. A home-like atmosphere;
9. Program is staffed by awake personnel 24 hours per day; and
10. Other requirements as listed in this chapter.

32-007.03C  Other Requirements: The residential treatment center must -

1. Be in conformance with all applicable federal, state, and local laws;
2. Meet the program and operational definitions and criteria contained in the Nebraska HHS Finance and Support Manual;
3. Meet the definition of a residential treatment center as stated in 471 NAC 32-007.02;
4. Maintain documentation in each client's treatment record that provides a full and complete picture of the nature and quality of all services provided (see 471 NAC 32-007.07);

5. Have the capacity to meet the needs of the individual Medicaid client either through employment of or contracts with appropriate staff (see 471 NAC 32-007.04D);

6. Be licensed by the Department under the minimum regulations for child caring agencies. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation (See 474 NAC 6-005, Licensing Group Homes and Child Caring and Placing Agencies and Nebraska State Statute 81-505.01, 1983.) Hospitals are not required to be licensed as a child caring agency.

32-007.03D Accreditation: The residential treatment center must have -

1. Be accredited by JCAHO, CARF, COA or AOA; or
2. Include a copy of the accreditation certificate with the initial and updated enrollment materials and forward a copy of all survey visit reports and provider responses.

If the most recent survey required a plan of corrections, the plan must also be submitted; or

Agencies accredited through these accrediting bodies are eligible for NMAP reimbursement of treatment and maintenance (room and board) costs and must maintain accreditation in order to qualify as a residential treatment services provider. Treatment and maintenance costs are reimbursed as a per diem rate. See NMAP Fee Schedule, (Appendix 471-000-532).

Interpretive Note: Agencies that have applied for accreditation with one of these entities may be enrolled on a provisional status and receive reimbursement for treatment only.

32-007.03E Staffing Standards for Participation: A residential treatment center for children shall meet the following standards to participate in NMAP:

1. The center's staff must include -
   a. An executive director who has a sufficient background and experience to administered a treatment program;
   b. A program director who meets the requirements of a clinical staff person in 471 NAC 32-001.04 and is operating within his/her scope of practice, with two years of professional experience in the treatment of children and adolescents with mental illnesses or emotional disturbances;
   c. Clinical staff professionals (who meet the requirements of a clinical staff person in 471 NAC 32-001.04) who provide psychotherapy and counseling, including face-to-face individual, family, and group counseling, who are directed by the supervising practitioner;
d. Child care staff who are age 21 or older and have specialized training and experience sufficient to equip them for their duties and are under the supervision of the program director. 75% of child care staff must have a bachelor's degree or five years of experience in human services field;

e. Supervisory staff will meet the standards outlined in 471 NAC 32-001.04 and four years experience in a related field.

f. Training must be approved by the Department and must meet the minimum standards for pre-service and on-going training in licensing requirements;

g. A supervising practitioner who is a licensed psychologist, physician, or doctor or osteopathy;

h. Each facility shall show by employment records or on a contractual basis the ability to provide the needed services as indicated by the scope of the program, including necessary medical/psychiatric evaluations, and access to emergency care. The clinical services of a psychologist, psychiatrist, and physician may be obtained on a consultation basis; and

j. Educators, when on-site education is provided. Services must be provided in accordance with applicable state and federal laws. NMAP does not make payment for educational services;

2. Volunteer services may be used to augment and assist other staff in carrying out program or treatment plans. Volunteers who work directly with youth must receive orientation training regarding the program, staff, and children of the center and the functions that volunteers can perform. However, the services performed by a volunteer cannot be substituted for necessary medical/psychiatric and therapeutic patient/staff ratios;

3. Staff must be mentally and physically capable of performing assigned duties and demonstrate basic professional competencies as required by the job description. Every staff member shall have an annual physical examination and obtain a statement that no medical condition exists that may interfere with his/her ability to perform assigned duties. This is addressed in policy governing licensure regulations. All applicable state, federal, and local laws must be followed.

4. All program personnel having access to clients, including full-time, part-time, paid, volunteer or contract, must be checked through the Central Registry, Adult Protective Services Registry, and the motor vehicle records. A criminal check must also be done through a law enforcement agency. A person whose name appears on any of the above registries must not have access to clients.
5. The ratio of professional staff to children is dependent on the needs of the children and commensurate with the size and scope of the program, however -  
   a. The minimum ratio of Master's level therapists providing direct face-to-face therapy services to children and families must be 1:10;  
   b. The supervising practitioner must be available to spend approximately 45 minutes (or more often as clinically necessary) per month, per client, in the facility as a minimum. This includes face-to-face time with the client, treatment plan reviews, and supervision;  
   c. There must be sufficient supervising practitioner consultation hours on a regular basis to meet the requirements for active treatment (see 471 NAC 32-007.06) and to properly supervise the Master's level therapists (see 471 NAC 32-007.03F). Youth at this level of care must be seen and interviewed by the supervising practitioner a minimum of once every 30 days.

6. The ratio of child care staff to children during prime time hours is dependent on the needs of the children and the requirements of the individualized treatment plans. The ratio of staff to children must be commensurate with the size and scope of the program; however, minimum ratio is 1:4. This may be increased depending on the intensity of the program and the child's needs.

7. The ratio of child care awake staff during sleeping and non-prime hours is dependent on the needs of the children and must be commensurate with the size and scope of the program; however, the minimum ratio is 1:6. This may be increased depending on the intensity of the program and the individual child's needs.

8. The facility must be able to call back child care staff to provide staff and client safety in crisis situations.

9. If the facility has a level program that requires intense observation for admissions, the direct care staff to youth ratio will need to be more intense during that observation period.

10. Access to emergency services such as additional supervision and medical/psychiatric care must be available on a 24-hour basis.

11. Those facilities providing this service prior to the effective date of this policy may apply to become an approved provider with their current staffing levels provided:  
   a. Any new staff hired must meet the criteria stated in these policies; and  
   b. Staff ratios are upgraded to policy standards within four months of the policy's effective date.
32-007.03F  Service Standards for Participation for Residential Treatment Centers:

Residential treatment centers shall -

1. Make every effort to keep the child in contact, when appropriate and possible, with the child's family and relatives, when reunification or reconciliation is the plan;
2. Involve the parents and family, when appropriate and possible, in the treatment planning. For wards of the Department, the case manager must be included in all phases of assessment, treatment planning, evaluation of services, and discharge/after care arrangements;
3. Provide a minimum of 42 hours of scheduled treatment intervention per week. These include, but are not limited to:
   a. Group psychotherapy by a practitioner operating within his/her scope of practice;
   b. Individual therapy by a practitioner operating within his/her scope of practice;
   c. Family intervention (one hour per week minimum);
   d. Face-to-face sessions with the supervising practitioner; and
   e. Other approved group or individual therapeutic activities.
4. Provide or arrange for face-to-face family therapy a minimum of twice a month. Depending on the child's needs, this may include reunification/reconciliation therapy and may also include biological families, foster families, adoptive families, and/or extended family;
5. Provide the following mandatory services -
   a. Clinically Necessary Nursing Services: Medical services directed by a Qualified Registered Nurse who evaluates the particular nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document approved by the supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
   b. Clinically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a Clinical Psychologist acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner.
   c. Clinically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse, or a staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a Medication Aide.
d. **Clinically Necessary Dietary Services**: The meal services provided must be supervised by a registered dietitian, based on the client's individualized diet needs. Programs may contract for these services through an outside licensed certified facility.

e. Transition and discharge planning must meet the requirements of 471 NAC 32-001.07A.

6. **Optional Services**: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy:

a. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
   (1) Recreational Therapy;
   (2) Speech Therapy;
   (3) Occupational Therapy;
   (4) Vocational Skills Therapy;
   (5) Self-Care Services: Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.

b. **Psychoeducational Services**: Therapeutic psychoeducational services may be provided as part of a total program. Therapeutic psychoeducational services must be provided by teachers specially trained to work with child and adolescents experiencing mental health or substance abuse problems. These services may meet some strictly educational requirements, but must also include the therapeutic component. Professionals providing these services must be appropriately licensed and certified for the scope of practice.

c. **Social Work Services by a Bachelor's Level Social Worker**: Social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment, i.e., case management type services.

d. **Crisis Intervention (may be provided in home)**;

e. **Social Skills Building**;

f. **Life Survival Skills**;

g. Substance abuse prevention, intervention, or treatment by an appropriately licensed alcohol and drug counselor.

7. **Provide appropriate conferences involving the youth's interdisciplinary treatment team**, the parents, the referring agency, and the child, to review the case status and progress at least every month. This does not substitute for documentation requirements. The need for conferences with interested parties is indicated by the individual child's circumstances and needs, which may indicate conferences occurring more frequently. For wards of the Department, this need will be jointly determined with the case manager;
8. Allow for more than one type of activity to be scheduled at one time allowing for specialized and individualized treatment planning;
9. Provide a progress report to the referring agency, and the parents or legal guardian every month for the purpose of service coordination. For wards of the Department, monthly reports must be provided to the Division of Children and Family Services case manager. The documentation from the Monthly Treatment Plan review may serve this purpose;
10. The services of specialists in the fields of medicine, psychiatry, psychology, and education must be used as needed.

32-007.03G Annual Update/Renewal: The residential treatment center shall submit the following information with the provider application and agreement, and update/renew the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and adolescents including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. The cost report; and
   f. The target population.
2. Confirmation that the staffing standards in 471 NAC 32-007.03E are met;
3. Copy of child caring agency licensure certificate; and
4. Copy of accreditation certificate.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-007.04 Covered Services: Medicaid limits payment for residential treatment services to those services for medically necessary to treat primary diagnoses. Medicaid covers residential services as delineated in 471 NAC 32-007 when the services are medically necessary and provide active treatment.

32-007.04A Pre-Admission Authorization: For residential treatment center services to be covered by Medicaid, the need for admission to this level of care must be determined by a supervising practitioner through a thorough Initial Diagnostic Interview and prior authorized through the Medicaid Division or its designee. For wards of the Department, consent for treatment for wards of the Department must be obtained from the Department case manager or supervisor. See 471 NAC 32-006.01, 32-006.03F, 32-006.04A, 32-006.05B.
32-007.04B Guidelines for Use of Residential Treatment Services for Children: A youth must have a diagnosable condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following guidelines to determine when residential treatment services for children or adolescents are medically necessary for a client:

1. The child/adolescent requires 24-hour awake supervision with high staff ratios;
2. Utilization of residential treatment services is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
3. The child/adolescent's problem behaviors are persistent, unpredictable, and may jeopardize the health or safety of the client and/or others;
4. The child/adolescent's daily functioning must be significantly impaired in multiple areas, such as family relationships, education, daily living skills, community, health, etc.;
5. The child/adolescent has a documented history of previous placement disruptions due to on-going behaviors/psychiatric issues; and
6. Less restrictive treatment approaches have not been successful or are deemed inappropriate by the referring supervising practitioner.

32-007.04C Therapeutic Passes for Clients Involved in Residential Treatment Services: Therapeutic passes are an essential part of the treatment for client/families involved in residential treatment services. Documentation of the client's continued need for residential treatment services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.
32-007.04D Vacations: If a residential treatment program takes the clients on a "vacation," NMAP will reimburse for those days under the following conditions -

1. The trip is prior authorized by the Division of Medicaid and Long-Term Care or its designee;
2. There is a clear statement of goals and objectives for the individual client's participation in the trip;
3. At least 50% of the scheduled treatment interventions must occur during the "vacation";
4. A clinical staff person must accompany the "vacation" trip; and
5. The "vacation" must be included in the treatment program.

NMAP will reimburse for up to seven "vacation" days per year for clients in residential treatment program.

32-007.05 Additional Requirements

32-007.05A Work Experience: When a center has a work program, it must -

1. Provide work experience that is appropriate to the developmental age and abilities of the child/adolescent;
2. Differentiate between the chores that children/adolescents are expected to perform as their share in the process of living together, specific work assignments available to children/adolescents as a means of earning money, and jobs performed in or out of the center to gain vocational training;
3. Give children/adolescents some choice in their work experience and offer change from routine duties to provide a variety of experiences;
4. Not interfere with the child/adolescent's time for school, study periods, play, chores, sleep, normal community activities, visits with the family, or individual, group, or family therapy.
5. Children/adolescents may not be solely responsible for any major phase of the center's operation or maintenance, such as cooking, laundering, housekeeping, farming, or repairing; and
6. Comply with all state and federal labor laws.

32-007.05B Solicitation of Funds: A center may not use a child/adolescent for advertising, soliciting funds, or in any other way that may cause harm or embarrassment to the child/adolescent or the family. Written consent of the parent or guardian must be obtained before the center uses a child's picture, person, or name in any form of written, visual, or verbal communication. Before obtaining consent, the center shall advise the parent or guardian of the purpose for which it intends to use the child's picture, person, or name, and of the times and places when and where this use would occur.
32-007.05C Special Treatment Procedures: If a youth needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in psychiatric RTC's are limited to physical restraint, locked time out (LTO), and a locked unit. Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardians or the Department case manager must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used.

Facilities must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO, physical restraints, or a locked unit.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

32-007.05D Medical Care: The center shall ensure that the following medical care is provided for each child/adolescent:

1. Each child/adolescent must receive a medical examination (EPSDT/Health Check exam) before or at the time of admission;
2. Each child/adolescent must have current immunizations as required by the Nebraska Department of Health and Human Services;
3. The center shall arrange with a physician and a psychiatrist for the medical and psychiatric care of the clients;
4. Each child/adolescent must have a medical examination annually as allowed in 471 NAC 33-000 ff.;
5. The center shall inform staff members of what medical care, including first aid, may be given by staff without specific physician orders. Staff must be instructed on how to obtain further medical care and how to handle emergency cases. The center shall ensure that:
   a. Staff members on duty must have satisfactorily completed current first aid and cardiopulmonary resuscitation training and have on file at the center a certificate of satisfactory completion as required by Department of Health and Human Services, Division of Public Health regulations;
   b. Each staff member must be able to recognize the common symptoms of illnesses in children/adolescents and to note any marked physical defects of children.
   c. A sterile clinical thermometer, a complete first aid kit, and clearly posted emergency phone numbers must be available, according to Department of Health and Human Services.

32-007.05E Hospital Admissions: The center shall make arrangements for the emergency admission of children from the center in case of serious illness, emergency, or psychiatric crisis. Parents, legal guardians, or the Department case manager or the case manager's supervisor must give permission and consent to treat for admission.

In the event that a client does require hospitalization while in a residential treatment center, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-007.05F Hospitalization or Death Reports: The center shall report any accident or illness requiring hospitalization to the parents or guardian immediately. The center shall immediately report any death to the parents or guardian, the Division of Medicaid and Long-Term Care, a law enforcement agency, and the county coroner. If the child is a Department ward, see 474 NAC 4-009.28D8.

32-007.05G Dental Care: Each child/adolescent must have an annual dental examination. If a child/adolescent has not had a dental exam in the twelve months before admission, an examination must occur within 90 days following admission. See 471 NAC 6-000 and 33-000 and 474 NAC 6-005.26F.
32-007.05H General Health: The center shall ensure the following:

1. Each child/adolescent must have enough sleep for the child/adolescent's age and physical and emotional condition at regular and reasonable hours, and under conditions conducive to rest. While clients are asleep, at least one staff member must be within hearing distance;
2. Children/adolescents must be encouraged and helped to keep themselves clean;
3. Bathing and toilet facilities must be properly maintained and kept clean;
4. Each child/adolescent must have a toothbrush, comb, an adequate supply of towels and washcloths, and personal toilet articles;
5. Menus must provide for a varied diet that meets a child/adolescent's daily nutritional requirements;
6. Each child/adolescent must have clothing for their exclusive use. The clothing must be comfortable and appropriate for the current weather conditions; and
7. The center must provide safe, age-appropriate equipment for indoor and outdoor play.

See 471 NAC 33-000.

32-007.05J Education: Educational services, when required by law, must be available. Education services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the NMAP.

32-007.05K Religious Education: Children/adolescent must be provided with an opportunity to receive instruction in their religion. No child/adolescent may be required to attend religious services or to receive religious instructions if the child/adolescent chooses not to attend the services or receive instruction.

32-007.05L Discipline: Discipline must be diagnostic and remedial rather than punitive. Corporal punishment, verbal abuse, and derogatory remarks about the child/adolescent, the family, religion, or cultural background are prohibited. A child/adolescent may not be slapped, punched, spanked, shaken, pinched, or struck with an object by any staff of the center. Only staff members of the center may discipline children (see 474 NAC 6-005.26K) while in treatment.
Transition and Discharge Planning: Whenever a child or adolescent is transferred from one setting to another, discharge planning must be performed and documented, beginning at the time of admission (see 471 NAC 32-001.07A and 474 NAC 6-005.27H).

Facilities must meet the following standards regarding discharge planning:

1. Discharge planning must be based on the multidisciplinary treatment plan designed to achieve the client's discharge from residential treatment status to a less restrictive level of care at the most appropriate time;
2. Discharge planning must address the client's need for ongoing treatment, continuing education, and support for normal development following discharge;
3. Discharge planning must include identification of and transition into services needed following discharge;
4. The residential treatment facility shall arrange for prompt transfer of appropriate records and information to ensure continuity of care following the client's discharge;
5. A written discharge summary must be provided as part of the clinical record; and
6. The client's family and caseworker must be active participants in discharge planning. This participation must be clearly documented in the client's record.

Notification of Runaway Children: See 390 NAC 7-001.05.

Interstate Compact on the Placement of Children: The center shall comply with the interstate compact on the placement of children (see 474 NAC 6-005.27J).

Medications: The center may possess a limited quantity of nonprescription medications and administer them under the supervision of designated staff. The center must follow all applicable regulations through the Department of Health and Human Services, Division of Public Health for storing and administering medications.

The center shall have written policies governing the use of psychotropic medications. Parents or the guardian of a client who receives psychotropic medication must be informed of the benefits, risks, side effects, and potential effects of medications. A parent or legal guardian's written informed consent for use of the medication must be obtained before giving the medication and filed in the client's record.

A child/adolescent's medication regime must be reviewed by the attending physician at least every seven days for the first 30 days and at least every 30 days thereafter.
32-007.06 Individual Treatment: To be covered by Medicaid, individual treatment services must include:

1. **Program philosophy:** Residential treatment facilities must provide intensive family-centered, community-based, developmentally appropriate services under the direction of a supervising practitioner.
   a. These services must be able to meet the special needs of families, including the "identified client" in the treatment facility. Families must be involved in treatment and discharge planning. For wards of the Department, the case manager must also be involved in treatment and discharge planning.
   b. The program intensity must be such that direct care staff, the client in treatment, and/or the client's family have access to professional staff on an "as needed" basis, determined by the client's condition.

2. **Active treatment,** which must be:
   a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed within 14 days of admission by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team.
   The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
   c. In compliance with 471 NAC 32-001.06, Active Treatment.

3. **Medically necessary services,** which must be an appropriate level of care based on documented Initial Diagnostic Interview including a comprehensive diagnostic workup and supervising practitioner-ordered treatment.

32-007.07 Documentation in the Client's Clinical Record: The center must maintain accurate clinical records indicating the degree and intensity of the treatment provided to clients who receive services in the residential treatment facility. For residential services, clinical records must stress the treatment intervention components of the clinical record, including history of findings and treatment provided for the psychiatric condition for which the client is in the facility. The clinical record must include the requirements stated in 471 NAC 32-001.05 and:

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every client at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;

4. The Initial Diagnostic Interview, including a medical/psychiatric history, which contains a record of mental status and notes the onset of illness/problems, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;

5. A complete psychological evaluation;

6. A complete neurological examination, when indicated;

7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;

8. A thorough family assessment;

9. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;

10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;

11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client, but should be recorded at least daily. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities;

12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge;

13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and

14. The client's response to therapeutic leave days prescribed by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

All documents from the client's medical record submitted to the Division of Medicaid and Long-Term Care must contain sufficient information for identification (i.e., client's name, date of service, provider's name).
32-007.08 Utilization Review: All facilities must have a utilization review protocol for their services.

32-007.09 Inspection of Care (IOC): The Division of Medicaid and Long-Term Care or its designee’s inspection of care team will conduct inspection of care reviews for psychiatric residential treatment facilities. See 471 NAC 32-001.09 and 471 NAC 32-001.10.

32-007.10 Documentation for Claims: The following documentation is required and kept in the client’s clinical record for all claims for residential treatment services. The facility will be notified in writing if that occurs:

1. The treatment plan;
2. Orders by the supervising practitioner; and
3. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-007.10A Exception: Additional documentation from the client’s clinical record may be requested by the Department prior to considering authorization of payment.

32-007.11 Costs Not Included in the Residential Treatment Per Diem: The mandatory and optional services are considered to be part of the per diem for residential treatment services. The following charges can be reimbursed separately from the residential treatment per diem when the services are necessary, part of the client’s overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

32-007.12 Procedure Code and Description for Residential Treatment Services: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.
32-008 Inpatient Psychiatric Services for Individuals Under Age 19 in Psychiatric Residential Treatment Facilities

32-008.01 Psychiatric Residential Treatment Facilities (PRTFs) for Children/Adolescents: A Psychiatric Residential Treatment Facility (PRTF) is a facility, other than a hospital, that provides inpatient psychiatric services to individuals under the age of 19. A PRTF must provide the inpatient psychiatric services under the direction of a physician, must be accredited and must comply with all the requirements of applicable state and federal regulations.

32-008.02 Prior Authorization: In order for an admission to a PRTF to be reimbursed by Medicaid, the individual must meet the Certification of Need for Services requirements set forth in 32-008.03 and be prior authorized by Medicaid or its designee. Prior authorization applies to all admissions described in 32-008.04.

32-008.03 Certification of Need for Services: A team specified in Section 32-008.04 must certify, prior to admission, that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the individual;
2. Proper treatment of the individual’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the individual’s condition or prevent further regression so that the services will no longer be needed.

32-008.04 Team Certifying Need for Services: Certification of the need for services specified in 32-008.03 must be made by an independent team that:

1. Includes a physician;
2. Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
3. Has knowledge of the individual’s situation.

32-008.04A Individuals Who Become Eligible for Medicaid While in PRTF: For an individual who applies for Medicaid while in the PRTF, the certification must be:

1. Made by the team responsible for the Plan of Care as specified in 32-008.07; and
2. Cover any period before application for which claims are made.

32-008.04B Emergency Admissions: For emergency admissions, the certification must be made by the team responsible for the Plan of Care within 14 days after admission.

32-008.05 Active Treatment: Inpatient psychiatric service must involve “active treatment” which means implementation of a professionally developed and supervised individual plan of care, as described in 32-008.06, that is developed and implemented no later than 14 days after admission and is designed to achieve the individual’s discharge from inpatient status at the earliest possible time.
32-008.06 Individual Plan of Care: The plan of care means a written plan developed for each individual to improve his/her condition to the extent that inpatient care is no longer necessary. The plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual’s situation and reflects the need for inpatient psychiatric care;
2. Be developed by a team of professionals specified in 32-008.07 in consultation with the individual and the parents, legal guardian or others in whose care the individual will be released after discharge;
3. State treatment objectives;
4. Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives; and
5. Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the individual’s family, school and community upon discharge. The discharge plan must:
   a. Identify the custodial parent or custodial caregiver anticipated at discharge;
   b. Identify the school the patient will attend;
   c. Include individualized educational program (IEP) recommendations as necessary;
   d. Outline the aftercare treatment plan; and
   e. List barriers to community reintegration and progress toward resolving these barriers since the last review. Include the needs of the custodial parent or custodial caregiver.

32-008.07 Team Developing Individual Plan of Care:

1. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to individuals in the facility.
2. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:
   a. Assessing the individual’s immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities;
   b. Assessing the potential resources of the individual’s family;
   c. Setting treatment objectives; and
   d. Prescribing therapeutic modalities to achieve the plan’s objectives.
3. The team must include, as a minimum, either:
   a. A Board-eligible or Board-certified psychiatrist; or
   b. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or
   c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed psychologist.
4. The team must also include one of the following:
   a. A psychiatric social worker;
   b. A licensed registered nurse with specialized training or one year’s experience in treating mentally ill individuals;
c. A licensed occupational therapist who has specialized training or one year of experience in treating mentally ill individuals.

d. A licensed psychologist.

32-008.08 Reports of Evaluations and Plans of Care: A written report of each evaluation and plan of care must be entered in the individual’s record:

1. At the time of admission; or
2. If the individual is already in the PRTF, immediately upon completion of the evaluation or plan.

32-008.09 Review of Plan of Care: The Plan of Care must be reviewed every 30 days by the team specified in 32-008.07, to:

1. Determine that services being provided continue to be required on an inpatient basis, and
2. Recommend changes in the plan as indicated by the individual’s overall progress from the treatment provided at this level of care.

32-008.10 Treatment Services Provided by the PRTF: Providers of PRTF services shall provide 40 hours of psychotherapy and other treatment interventions per week. The following services and frequency of services are included in the PRTF rate and must be available to the individual unless clinically contraindicated:

1. Twice weekly individual psychotherapy and/or substance abuse counseling;
2. Minimum three times a week group psychotherapy and/or substance abuse counseling;
3. Weekly family psychotherapy and/or family substance abuse counseling. A family therapy session is provided on the day of admission and the day prior to discharge;
4. Occupational therapy as clinically indicated;
5. Physical therapy as clinically indicated;
6. Speech therapy as clinically indicated;
7. Laboratory services;
8. Transportation; and
9. Medical Services, as necessary; and
10. Nursing service availability 7 days a week, 365 days a year by an onsite nurse during awake hours and by an on-call availability during sleep hours.

32-008.11 Psychoeducation Services Provided in PRTF: Psychoeducational services must be available from the PRTF and must be modified to meet the unique treatment needs of the individual as described in the individual’s Plan of Care:

1. Crisis intervention and aftercare planning;
2. Life survival skills as clinically indicated;
3. Social skills building;
4. Substance abuse prevention interventions;
5. Self-care services as clinically indicated;
6. Medication education, compliance and information regarding the effectiveness of medication;
7. Health care issues which may include nutrition, hygiene and personal wellness;
8. Vocational/career planning as clinically indicated; and
9. Recreational activity (recreational activity is not considered in 40 hours per week of therapy but healthful outcomes of recreation and exercise may be a part of a psycho-educational group service).

32-008.12 Individual Participation in PRTF Services: Every individual need not partake in all treatment services that are available in the PRTF if such services are clinically contraindicated. If individual, group or family psychotherapy services are not appropriately beneficial to the individual’s need and Plan of Care, the Plan of Care shall identify the rationale for this omission. However, in no case should a child/adolescent receive less than 40 hours of PRTF services each week.

32-008.13 Staffing Standards for PRTFs: A PRTF shall be available 24 hours a day, 7 days a week, 365 days per year with 24-hour awake staffing. Staffing ratios should be 1:4 during awake hours and 1:6 during sleep hours. The following positions are required to be staffed, with a minimum of the stated qualifications.

32-008.13A Supervising Practitioner: The PRTF Supervising Practitioner shall be a licensed physician.

32-008.13B Program/Clinical Director: A program/clinical director shall be a LMHP, licensed RN, licensed APRN, LIMHP, licensed physician with a specialty in psychiatry, or licensed psychologist. Dual-credentialing (e.g., LMHP/LADC or LMHP/PLADC) is required for PRTF services when co-occurring conditions (e.g. mental health and substance abuse) occur. The Program/Clinical Director shall have two years professional experience in a treatment setting similar to a PRTF. The Program/Clinical Director may not also serve in the role of the program’s therapist.

32-008.13C PRTF Therapist: A PRTF therapist shall be a licensed practitioner whose scope of practice includes mental health and/or substance abuse services, including a LMHP, LIMHP, PLMHP, LADC, licensed psychologist, provisionally licensed psychologist, licensed APRN, or licensed physician with a specialty in psychiatry.

32-008.13D Registered Nurse or Advanced Practicing Registered Nurse (RN or APRN): Nursing services shall be provided by a Registered Nurse or APRN licensed by the State in which she or he practices.

32-008.13E Direct Care Staff: Direct care staff shall meet the following requirements: Be 21 years of age or older and at least three years older than the oldest resident and have a high school diploma or its equivalent. Direct care staff shall be appropriately trained and responsible for basic interaction care such as supervision, daily living care and mentoring of the residents as well as assisting in the implementation of the plan of care that is within their scope of practice.
32-008.14 Restraint and Seclusion: Restraint and seclusion activities utilized by the PRTF shall be in compliance with federal standards for restraint and seclusion.

32-008.15 Services Provided Outside the PRTF: The following services must be available to the individual and may be billed separately to Medicaid:

1. Medically necessary services and/or supplies, including dental, vision, diagnostic radiology and prescribed medications, not otherwise included in the PRTF rate when that care is reflected in the plan of care.

2. The PRTF shall:
   a. Arrange for and oversee the provision of such services and/or supplies;
   b. Maintain all medical records of care furnished to the individual; and
   c. Ensure that all services and/or supplies are furnished under the direction of a physician.
Inpatient Mental Health Services for Clients 20 and Younger in Institutions for Mental Disease (IMD's): Inpatient mental health services in an Institution for Mental Disease (IMD's) are available to clients age 20 and younger when the client participates in a HEALTH CHECK (EPSDT) screen, and the treatment is medically necessary. Inpatient mental health services in an IMD must be family centered and community based culturally competent, and developmentally appropriate.

Services for wards of the Department must be prior-authorized by and consent for treatment must be obtained from the ward's case manager or the case manager's supervisor.

32-009.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) covers IMD services under 42 CFR 431.620(b), 435.1009; 440.140; 440.160; Part 441, Subparts C and D; Part 447, Subparts B and C; Part 456, Subparts D and I; and Part 482. The Department provides IMD services under the Family Policy Act, Sections 43-532 through 534. Reissue Revised Statute of Nebraska, 1943.

32-009.02 Definition of an IMD: 42 CFR 435.1009 defines an IMD as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." This is limited to free-standing facilities which are not excluded units of acute care hospitals.

32-009.03 Covered Services: Under 42 CFR 440.160, NMAP covers services in IMD's for individuals age 20 and younger.
32-009.04 Standards for Participation: To participate in the NMAP, the IMD must -

1. Be in conformity with all applicable federal, state, and local laws;
2. Be licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or the licensing agency in the state where the IMD is located;
3. Be certified as meeting the conditions of participation for hospitals in 42 CFR Part 482;
4. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and submit a copy of the most recent accreditation survey with Form MC-20;
5. Meet the definition of an IMD as stated in 471 NAC 32-009.02 (above);
6. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
7. Meet the current JCAHO or AOA standards of care; and
8. Meet all requirements in 471 NAC 32-001 and 471 NAC 32-008.

32-009.04A Provider Agreement: The provider shall complete Form MC-20 and submit the form, along with a copy of its current JCAHO or AOA accreditation survey, program, policies, and procedures to the Department to enroll in NMAP as a provider. If approved, the Department notifies the IMD of its provider number.

32-009.04B Annual Update: With the annual cost report, the provider shall submit a copy of all program information, their most recent license and accreditation certificates, and any other information specifically requested by the Department. Claims will not be paid if this has not been received and approved.

32-009.04C Monthly Reports: The IMD shall submit a monthly report to the Division of Medicaid and Long-Term Care. The report must contain -

1. The names of all Medicaid clients admitted or discharged during the month; and
2. The date of each Medicaid client’s admission or discharge.

The report must be submitted by the 15th of the following month.
32-009.04D Record Requirements: Transfer to another IMD or readmission constitutes a new admission for the receiving facility.

The psychiatrist shall complete, sign, and date Form MC-14 within 48 hours after admission. If an individual applies for assistance while in the facility, copies of the admission notes and plan of care must be attached to the signed Form MC-14 to certify that inpatient services are or were needed.

32-009.04D1 An Individual Who Applies For NMAP While in the IMD: For an individual who applies for NMAP while in the IMD, the certification must be:

1. Made by the team that develops the individual plan of care (see 471 NAC 32-009.09F);
2. Cover any period before application for which claims are made.

When Medicaid eligibility is determined, authorization for previous and continued care must be obtained from the Department contracted peer review organization or management designee.

32-009.05 General Definitions: The following definitions are used in this section:

Interdisciplinary Team: The team responsible for developing each client's individual plan of care. The team must include a board-certified psychiatrist. The team must also include at least two of the following:

1. Licensed Mental Health Practitioner;
2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;
3. An occupational therapist who is licensed, if required by state law, and who has specialized training or one year's experience in treating mentally ill individuals; or
4. A clinical psychologist.

Inpatient Hospital Services for Individuals Age 20 or Younger in Institutions for Mental Disease (IMD's): Services provided under the direction of a psychiatrist for the care and treatment of clients age 20 and younger in an institution for mental disease that meets the requirements of 42 CFR 440.160.

Inspection of Care Team: The Department or designee's inspection of care team, consisting of a psychiatrist knowledgeable about mental institutions, a qualified registered nurse, and other appropriate personnel as necessary who conduct inspection of care reviews under 42 CFR 456.600-614 and 471 NAC 32-009.07 ff.

Medical Review Organization: A review body contracted by the Department, responsible for pre-admission certification and concurrent and retrospective reviews of care.
32-009.06 Payment for IMD Services: See 471 NAC 10-010.03 ff.

32-009.06A Therapeutic Passes from Institution for Mental Disease Settings: For some psychiatric clients, therapeutic passes are an essential part of treatment. For those clients, documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes. Payment for hospitalization beyond a second pass is not available.

32-009.06B Unplanned Leaves of Absence from Institution for Mental Disease Settings: Payment for hospitalization during an unplanned leave of absence from inpatient settings is not available. If a client returns to a hospital after an unplanned absence, the readmission must be approved by the Department contracted peer review organization or management designee.

32-009.07 Inspections of Care: Under 42 CFR 456, Subpart I, the Department or designee's inspection of care team shall periodically inspect the care and services provided to clients in each IMD under the following policies and procedures.

32-009.07A Inspection of Care Team: The inspection of care team must meet the following requirements:

1. The inspection of care team must have a psychiatrist who is knowledgeable about mental institutions and other appropriate mental health and social service personnel;
2. The team must be supervised by a physician, but coordination of the team's activities remains the responsibility of the Division of Medicaid and Long-Term Care or their designee;
3. A member of the inspection of care team may not have a financial interest in any institution of the same type in which s/he is reviewing care but may have a financial interest in other facilities or institutions. A member of the inspection of care team may not review care in an institution where s/he is employed, but may review care in any other facility or institution.
4. A physician member of the team may not inspect the care of a client for whom s/he is the attending physician.
5. There must be a sufficient number of teams so located within the state that on-site inspections can be made at appropriate intervals in each facility caring for clients.

32-009.07B Frequency of Inspections: The inspection of care team and the Department shall determine, based on the quality of care and services being provided in a facility and the condition of clients in the facility, at what intervals inspections will be made. However, the inspection of care team shall inspect the care and services provided to each client at least annually, and/or more frequently as determined by the Inspection of Care team.
32-009.07C Notification Before Inspection: No facility may be notified of the time of inspection more than 48 hours before the scheduled arrival of the inspection of care team. The review team may make unannounced inspections at their discretion.

32-009.07D Personal Contact With and Observation of Recipients and Review of Records: For clients age 20 and younger, the team's inspection must include:

1. Personal contact with and observation of each client;
2. Review of each client's medical record; and
3. Review of the facility's policies as they pertain to direct patient care for each client being reviewed in the inspection of care, in accordance with 42 CFR 456.611(b)(1).

32-009.07E Determinations by the Team: The inspection of care team shall determine in its inspection whether:

1. The services available in the IMD are adequate to:
   a. Meet the health needs of each client; and
   b. Promote his/her maximum physical, mental, and psychosocial functioning;
2. It is necessary and desirable for the client to remain in the IMD;
3. It is feasible to meet the client's health needs through alternative institutional or noninstitutional services; and
4. Each client age 20 or younger in a psychiatric facility is receiving active treatment as defined in 42 CFR 441.1 and 471 NAC 32-009.05.

If, after an inspection of care is complete, the inspection of care team determines that a follow-up visit is required to ensure adequate care, a follow-up visit may be initiated by the team. This will be determined by the inspection of care team and will be noted in the inspection of care report.

32-009.07F Basis for Determinations: Under 42 CFR 456.610, in making the determinations by the team on the adequacy of services and other related matters, the team will determine what items will be considered in the review. This will include, but is not limited to, items such as whether:

1. The psychiatric and medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care, and when required, the plan of rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded;
2. The attending physician reviews prescribed medications at least every 30 days;
3. Test or observations of each client indicated by his/her medication regimen are made at appropriate times and properly recorded;
4. Physician, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the client;
5. The client receives adequate services, based on such observations as -
   a. Cleanliness;
   b. General physical condition and grooming;
   c. Mental status;
   d. Apparent maintenance of maximum physical, mental, and psychosocial function;
6. The client receives adequate rehabilitative services, as evidenced by -
   a. A planned program of activities to prevent regression; and
   b. Progress toward meeting objectives of the plan of care;
7. The client needs any services that are not furnished through the IMD or through arrangements with others;
8. The client needs continued placement in the IMD or there is an appropriate plan to transfer the client to an alternate method of care, which is the least restrictive, most appropriate environment that will still meet the client's needs.
9. Involvement of families and/or legal guardians (see 471 NAC 32-001); and
10. The facility's standards of care and policy and procedure meets the requirements for adequacy, appropriateness, and quality of services as they relate to individual Medicaid clients, as required by 42 CFR 456.611(b)(1).

32-009.07G Reports on Inspections: The inspection of care team shall submit a report to the Administrator of the Medicaid Division on each inspection. The report must contain the observations, conclusions, and recommendations of the team concerning -

   1. The adequacy, appropriateness, and quality of all services provided in the IMD or through other arrangements, including physician services to clients; and
   2. Specific findings about individual clients in the IMD.

The report must include the dates of the inspection and the names and qualifications of the team members. The report must not contain the names of clients; codes must be used. The facility will receive a copy of the codes.

32-009.07H Copies of Reports: Under 42 CFR 456.612, the Department shall send a copy of each inspection report to -

   1. The facility inspected;
   2. The IMD's utilization review committee;
   3. The Nebraska Department of Health and Human Services, Division of Public Health; and
   4. The Nebraska Department of Health and Human Services, Division of Behavioral Health.

If abuse or neglect is suspected, Medicaid staff shall make a referral to the appropriate investigative body.
32-009.07J Facility Response: Within 15 days following the receipt of the inspection of
care team's report, the IMD shall respond to the Central Office in writing, and shall include
the following information in the response:

1. A reply to any inaccuracies in the report. Written documentation to substantiate
the inaccuracies must be sent with the reply. The Department will take
appropriate action to note this in a follow-up response to the facility;
2. A complete plan of correction for all identified Findings and Recommendations;
3. Changes in level of care or discharge of individual clients;
4. Action to individual client recommendations; and
5. Projected dates of completion on each of the above.

If additional time is needed, the facility may request an extension.

At the facility's request, copies of the facility's response will be sent to all parties who
received a copy of the inspection report in 471 NAC 32-009.07H.

A return site visit may occur after the written response is received to determine if changes
have completely addressed the review team's concerns from the IOC report.

The Department will take appropriate action based on confirmed documentation on
inaccuracies.

32-009.07K Department Action on Reports: The Department will take corrective action
as needed based on the report and recommendations of the team submitted under this
subpart.

32-009.07L Appeals: See 471 NAC 2-003 ff. and 465 NAC 2-001.02 ff. and 2-006 ff.

32-009.07M Failure to Respond: If the IMD fails to submit a timely and/or appropriate
response, the Department may take administrative sanctions (see 471 NAC 2-002 ff.) or
may suspend NMAP payment for an individual client or the entire payment to the facility.
32-009.08  Inpatient Mental Health Services for Individuals Age 20 and Younger in an IMD: NMAP covers inpatient mental health services in an IMD for individuals age 20 and younger under 42 CFR 440.160. The following requirements must be met to receive NMAP payment for these services.

32-009.08A  Admission Criteria: See 471 NAC 32-008.05.

32-009.08B  Admission Evaluation: A psychiatrist shall make an admission evaluation when the client is admitted to the hospital. The admission evaluation must include -

1. An initial assessment, within 24 working hours of the admission, of the health status and related psychological, medical, social, and educational needs of each individual client;
2. A determination of the range and kind of services required; and
3. If all admission criteria have been met, this evaluation must include an initial treatment plan.

32-009.08C  Treatment Plan Requirements:

1. The treatment plan must meet the guidelines in 471 NAC 32-001 and in 42 CFR 441.155 and 441.156; and
2. The treatment plan must be developed by the psychiatrist and the Interdisciplinary Team defined in 471 NAC 32-009.08H.

32-009.08C1  Review of Plan of Care: Under 42 CFR 441.155(c), the facility interdisciplinary team shall review the plan of care every 30 days to -

1. Determine that services being provided are or were required on an inpatient basis; and
2. Recommend changes in the plan of care as indicated by the client's overall adjustment as an inpatient.

This review also serves as the recertification of need for services.

The individual plan of care must be developed by the facility interdisciplinary team.
32-009.08D Prior Authorization Procedures: IMD services for clients age 20 and younger must be prior-authorized as follows:

1. The psychiatrist/physician shall complete, sign, and date Form MC-14 within 48 hours after admission or at the time of application for medical assistance if this date is later than the date of admission. The 48-hour period does not include weekends or holidays. Copies of the admission notes and plan of care may be attached to the signed and dated Form MC-14 to certify that inpatient services are or were needed.

2. The facility shall contact the client's local office for determination of medical eligibility. The local office shall respond to the facility with:
   a. The medical eligibility effective date; and
   b. The date eligibility was determined, if this date is later than the date of admission.

3. The facility shall complete Form MC-9H, attach a copy of the completed Form MC-14, and forward to the Division of Medicaid and Long-Term Care. The facility shall retain the original copy of Form MC-14 in the client's medical record.

4. The Division of Medicaid and Long-Term Care shall review Form MC-14 and approve or reject the Form MC-14 findings within 15 days.

5. If rejected, the Division of Medicaid and Long-Term Care shall return all forms to the facility with an explanation of the rejection.

6. If approved, the Division of Medicaid and Long-Term Care shall complete Block #11 and the signature Block #18 of Form MC-9H. The white copy is retained in Central Office. The Central Office shall send the pink and gold copies to the facility and the yellow copy to the local office.

7. The document number on Form MC-9H must be entered in Form Locator 63 on each Form CMS-1450 or standard electronic Health Care Claim: Institutional transaction submitted to the Department. One carbon copy of Form MC-9H may be attached to the first claim submitted.

8. When the client is discharged or expires, the facility shall complete Form MC-10 to close the authorization. The facility shall forward the white copy to the Central Office and the yellow copy to the local office, and retain the pink and gold copies. Within 48 hours after a client is discharged or expires, the facility shall notify the client's local office.
32-009.08D1 Transfers: Transfer to another IMD or a readmission constitutes a new admission for the receiving facility. This procedure must be followed for each transfer or readmission.

32-009.08E Certification of Need for Services: For persons becoming Medicaid eligible after admission, in accordance with 42 CFR 441.152, the facility interdisciplinary team shall certify that -

1. Ambulatory care resources available in the community do not meet the treatment needs of the client;
2. Proper treatment of the client's psychiatric conditions requires services on an inpatient basis under the direction of a psychiatrist; and
3. The services can reasonably be expected to improve the client's condition or prevent further regression so that the services will no longer be needed.

The certification must be made at the time of admission, or if the individual applies for the NMAP while in the IMD, before the Department authorizes payment. This is accomplished by completion of Form MC-14. The form must be signed by the team physician/psychiatrist making the determination. A copy of the physician referral must accompany the completed MC-14.

32-009.08F Initial Certification: A psychiatrist shall pre-certify, at the time of admission, that the client requires inpatient services in a psychiatric hospital. The psychiatrist shall complete Form MC-14 at the time of admission or within 48 hours of admission. If the individual applies for NMAP while in a psychiatric hospital, the psychiatrist shall certify the client's needs before the Department authorizes payment.

32-009.08G Sixty-Day Recertification: A psychiatrist shall recertify, in the client's record, the client's need for continued care in a mental hospital or need for alternative arrangements at least every 60 days after the initial certification.

32-009.08H Interdisciplinary Plan of Care: The psychiatrist and the facility interdisciplinary team shall develop and implement an individual written plan of care for each client within 48 hours after the client's admission. This plan of care must be placed in the client's chart when completed. The written plan of care must include -

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the client's functional level;
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 recommended for the client's health and safety;

5. Plans for continuing care, including review and modification of the plan of care;
6. Appropriate medical treatment in the IMD every 60 days;
7. Appropriate social services every 60 days; and
8. Plans for discharge, including referrals for outpatient follow-up care.

Care plans must address family involvement.

This requirement may be met by completion of Form MC-14, which is retained in the client's record.

32-009.08J Required Psychiatrist Services: The client must be treated by a psychiatrist at least six out of seven days, or frequently as medically necessary and the interaction must be documented in the client's medical record.

32-009.08K Facility Interdisciplinary Plan of Care Team Review: The attending or staff psychiatrist and other personnel involved in the client's care shall review each plan of care at least every 30 days. The client's record must contain documentation of the 30-day interdisciplinary team review.

32-009.08L Admission Evaluation: IMD staff shall develop an admission evaluation for each client within 30 days after the client's admission. This evaluation must be placed in the client's record when completed. The admission evaluation must include -

1. The Form MC-14 (see 471 NAC 32-009.08E).
2. A medical evaluation, including -
   a. Diagnosis;
   b. Summary of current medical findings;
   c. Medical history;
   d. Mental and physical functional capacity;
   e. Prognosis;
   f. The psychiatrist's recommendation concerning the client's admission to the mental hospital or the client's need for continued care in the mental hospital, if the client applies for NMAP while in the mental hospital;
3. A psychiatric evaluation;
4. A social evaluation;
5. An initial plan of care sufficient to meet the client's needs until the facility interdisciplinary team has developed the individual written plan of care.
Discharge Planning: The IMD shall make available to the psychiatrist current information on resources available for continued out-of-hospital care of patients and shall arrange for prompt transfer of appropriate medical and nursing information to ensure continuity of care upon the client's discharge. The IMD is responsible for discharge planning. In cooperation with community regional mental health programs, the IMD shall -

1. Initiate alternate care arrangements;
2. Assist in client transfer; and
3. Follow-up on the client's alternate care arrangements.

When the client is being transferred to a long term care facility (NF or ICF/MR), the facility's staff must be included in the discharge process and must receive appropriate and adequate medical and nursing information to ensure continuity of care. The IMD shall also contact the client's local office.

Payment for Inpatient Mental Health Services in an Institution for Mental Disease: See 471 NAC 10-010.03 ff., 32-008.09, and 32-008.12.

Other Regulations: In addition to the policies regarding mental health services, all regulations in the Nebraska Department of Health and Human Services Manual apply, unless stated differently in this section.
Chapter 33-000  HEALTH CHECKS and Treatment Services for Conditions Disclosed During HEALTH CHECKS (EPSDT)

33-001  Introduction

33-001.01  Legal Basis: HEALTH CHECKS are covered under the Early and Periodic Screening, Diagnosis, and Treatment Program which was established by Title XIX of the Social Security Act. Section 1905(r) of the Social Security Act was added by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

33-001.01A  Annual Participation Goals: Section 1905(r) of the Social Security Act also mandates setting annual participation goals for screening services.

33-001.02  Purpose and Scope: HEALTH CHECK, the Nebraska Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a service available to all individuals age 20 and younger eligible for medical assistance. The goal is to provide each eligible individual the opportunity for achieving and maintaining optimal health status. This can be facilitated by early detection of illness or defects through regular and periodic screening examinations, by providing follow-up care of the conditions detected during the screening, by providing continuity of care, and by promoting healthy lifestyles. It is intended to encourage and ensure that treatment is available and received by those eligible and in need of treatment by the application of medical knowledge and technology to cure, correct, or alleviate health problems. Preventive health care provides the following benefits:

1. Early detection and treatment of health problems to prevent serious impairment and to increase the chance of successful treatment;
2. Protection from certain preventable diseases by immunization for children at an early age;
3. Maintenance of good health and assurance of normal development through periodic check-ups and the establishment of a "medical home." In most cases, this will be a continuing relationship with a primary care physician; and
4. Savings of future medical costs.

The EPSDT program's objectives are ensuring the availability and accessibility of required health care resources and helping Medicaid-eligible children and their parents or caretakers effectively use them. This may be accomplished through care coordination. Care coordination includes:

1. Provision of effective outreach/education activities which inform parents of the benefits of having their children receive HEALTH CHECK screening, diagnosis, and treatment services;
2. Provision of consumer education to parents which assists in making responsible decisions about participation in preventive health care and appropriate utilization of health care resources;
3. Assurance of continuing and comprehensive health care beginning with the screening through diagnosis and treatment for conditions identified during screening;
4. Provision of assistance to families in making medical and dental appointments and in obtaining needed transportation; and
5. Establishment of case management of screening services to monitor and document that all HEALTH CHECK (EPSDT) services are delivered within established time frames.

This may be accomplished through interagency agreement, managed care contract, or fee for service with qualified Medicaid-enrolled providers as determined by the NMAP. Examples of EPSDT participants in particular need of care coordination may be pregnant adolescents, children with special health care needs, medically fragile children, foster care children, and children with significantly environmental risk.

33-001.03 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC):
Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

33-001.03A HMO Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

33-001.03B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

33-001.03C HEALTH CHECK Under NHC: HEALTH CHECK services are covered services under the Nebraska Health Connection (NHC). EPSDT participants enrolled with capitated (HMO) plans or PCCM network should receive HEALTH CHECK health screening services from their primary care physician (PCP). Plans are to meet the annual participation goals as required under contract.

When vision, hearing, and dental screening examinations are included in the HMO capitated plan in which the EPSDT participant is enrolled, the vision, hearing, and dental screening provider must work with the Plan for payment. These screening services must be available according to the established periodicity schedules in 471 NAC 33-002.03 and under the guidelines for interperiodic examinations in 471 NAC 33-002.04.
Vision, hearing, and dental screening examinations for HMO enrollees whose plan does not include these in the capitated rate do not require PCP referral and can be obtained from any qualified Medicaid-enrolled provider. Independent hearing screening exams require referral management from the PCCM plan. Providers should contact the plan before providing services. Vision and dental screening for PCCM enrollees will not require PCP referral. Prior authorization is prohibited for HEALTH CHECK screening exams.

Services that are identified as a result of a HEALTH CHECK screen that are not covered under the Nebraska Medicaid Assistance Program are not included in the NMMCP. These services require prior authorization per 33-001.03, Treatment Services.

33-001.04 Definition of Terms: The following terms are defined in relation to HEALTH CHECK and treatment services under the EPSDT program.

Early: As soon as an individual's or a family's eligibility for assistance has been established; or, in the case of a family already receiving assistance, as early as possible in the individual's life. This includes informing Medicaid-eligible pregnant women so that prevention begins prenatally.

Periodic: Intervals established for examination or screening to ensure continued health and to detect conditions requiring treatment. Dental screening examinations are recommended for children following eruption of their first tooth, but no later than age one according to the American Dental Association. Medical, visual, and hearing exams are to begin with a neonatal exam and follow, at a minimum, the periodicity schedule based on the American Academy of Pediatrics schedule for health supervision visits (see 471 NAC 33-002.03). The physician may establish an alternate periodicity schedule based on medical necessity. The initial examination of a newborn is considered an initial HEALTH CHECK (EPSDT) examination and the child is considered participating in the program. All well-baby and well-child examinations are to be reported as HEALTH CHECK examinations through the HEALTH CHECK (EPSDT) program.

Screening Services: Periodic child health assessments which are regularly scheduled to examine and evaluate the general physical and mental health, growth, development and nutritional status of eligible children. The screenings are performed to identify individuals who may require diagnosis, further examination, and/or treatment. Prior authorization approval of health, dental, vision, and hearing screening examinations for EPSDT participants is prohibited. The following screening services are included in the EPSDT benefit:

1. Health Screening Services:
   a. Comprehensive health and developmental history (including assessment of both physical and mental health development);
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations for age and for health history;
d. Appropriate laboratory procedures, including blood lead testing for age and populations groups; and
e. Health education (including anticipatory guidance);

2. **Dental Screening Services**: For children age one and older, dental screening services are furnished by direct referral to a dentist. Medically necessary and reasonable diagnosis and treatment including, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of health are covered;

3. **Vision Screening Services**: An age-appropriate visual assessment. Medically necessary and reasonable diagnosis and treatment for defects in vision are covered; and

4. **Hearing Screening Services**: An age-appropriate hearing assessment. Medically necessary and reasonable diagnosis and treatment for defects in hearing are covered.

**Diagnosis**: The determination of the nature or cause of a physical or mental disease or abnormality. A diagnosis enables a physician to make a plan for treatment specific to the EPSDT participant’s problems. Under certain circumstances, diagnosis may be provided at the same time as screening. In other circumstances, diagnosis may be provided during a second appointment. The diagnosis may or may not require further follow-up. It may result in referral for treatment.

**Treatment Services**: HEALTH CHECK (EPSDT) follow-up services necessary to diagnose or to treat a condition identified during a HEALTH CHECK (EPSDT) health, visual, hearing, or dental screening examination are covered under the following conditions:

1. The service is required to treat the condition (i.e., to correct or ameliorate defects and physical or mental illnesses or conditions) identified during a periodic or interperiodic HEALTH CHECK (EPSDT) screening examination and documented;
2. The provider of services is a Medicaid-enrolled provider;
3. The service is consistent with applicable federal and state laws that govern the provision of health care;
4. The service must be medically necessary, safe and effective, not considered experimental/investigational (see 471 NAC 10-004.05), and must be generally employed by the medical profession;
5. Supplies, items, or equipment that is determined to be not medical in nature will not be covered;
6. Where alternative and medically appropriate modes of treatment exist and are available the NMAP may choose among the alternatives which services are available based on cost-effectiveness;
7. Services currently covered under the Nebraska Medical Assistance Program will be governed by the guidelines of NMAP;

8. Services not covered under the Nebraska Medical Assistance Program but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 6 (above). Criteria and requirements for certain services are outlined in this Chapter. Unless otherwise outlined, all services not covered under NMAP must be prior authorized by the Medicaid Division, Department of Health and Human Services Finance and Support. Requests for prior authorization must be submitted to: Nebraska Department of Health and Human Services Finance and Support, Medicaid Division. The provider shall submit requests for NMAP prior authorization using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or by completing and submitting a written request. The request must include:

   a. A copy of the screening exam form or the name of the screening practitioner and the date of the screening exam which identified the condition; and

   b. A plan of care which includes:
      1. History of the condition;
      2. Physical findings and other signs and symptoms, including appropriate laboratory data;
      3. Recommended service/procedure, including (if known) the potential provider of service (e.g., equipment, supplies) or where the services will be obtained;
      4. Estimated cost, if available; and
      5. Expected outcome(s).

The plan of care may be submitted on Form EPSDT-5, "Plan of Care," (see 471-000-38) or as a statement by the screening practitioner. The Medical Director or designee shall make a decision on each request in an expeditious manner. Appropriate health care professionals may be consulted during the decision-making process. A response will be sent to the screening practitioner, managed care plan if an enrollee, and the client's worker in the local HHS office. For wards of the Department, a response is sent to the client's case manager in the local office. If the initial request is denied, additional information may be sent for reconsideration.

33-002 HEALTH CHECKS (EPSDT Screening Evaluations): The screening examination is performed to identify those health problems which require further examination and/or treatment. Form CMS-1500 for HEALTH CHECK health screening services (see 471-000-62) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) is designed to:

1. Report the screening findings during the screening examination;

2. Report services associated with the screening exam as defined in 471 NAC 33-003, HEALTH CHECK (EPSDT) Special Services; and

3. Claim charges for these services.

The Recommendations for Preventive Pediatric Health Care published by the American Academy of Pediatrics (see 471 NAC 33-002.03) are recommended as guidelines for content and minimum frequency for HEALTH CHECK (EPSDT) examinations. The initial newborn assessment in the hospital is considered a HEALTH CHECK screening. Total obstetrical care fulfills the requirement of a HEALTH CHECK examination for EPSDT participants.
Screening physicians using the appropriate professional claim form or electronic format (see Claim Submission Table at 471-000-49) will be subject to random selection of medical chart review to assure the minimum components of the screening examination are performed.

33-002.01 Screening Providers: Screening services are to be performed by or under the supervision of a physician, dentist, or other provider qualified under State and Federal law to furnish primary medical and health services. Periodic and interperiodic examinations shall, at a minimum, include the health screening services defined in 471 NAC 33-001.03 (see item 1 of the definition of Screening Services). Vision and hearing screening examinations cannot be limited to the screening physician but may be obtained directly from an ophthalmologist or optometrist for vision services and licensed audiologist for the hearing service. In an effort to support the "medical home" concept or a permanent primary care relationship and to avoid fragmentation or duplication of services, the provision of vision and hearing screening provided within the context of the health screening is encouraged. If not performed with the health screening, care coordination with the primary physician is recommended (see 471 NAC 33-001.03).

33-002.02 Components of Health Screening: Each health screening must at a minimum include the components A-E (defined in 471 NAC 33-002.02A through 33-002.02E), and at the screening physician's judgment components F-H (defined in 471 NAC 33-002.02F through 33-002.02H). Component F, vision screening and component G, hearing screening, may be obtained directly from a qualified provider of these screening services. See 471 NAC 24-000 for policy relating to coverage of vision services and 471 NAC 23-000 for policy relating to coverage of hearing services.

Note: If a component is not performed based on the physician's judgment, the physician documents the reason in the medical record.

33-002.02A Health and Developmental History: This information may be obtained from the parent or responsible adult familiar with the child at the time of the screening or prior to the screening through interview and by use of the physician's history form. The history is to include contact information, a description of the family, and medical, developmental and behavioral information on the child and the family. A comprehensive history is to be obtained on the initial examination and updated at subsequent periodic examinations. Developmental surveillance may include a review of gross and fine motor development, language development, self-help skills, social-emotional development, and cognitive skills. It is a review of developmental progress within the context of overall health and well-being, given the child's age and culture. If a formal development test is given to assess development, it may be billed separately from the full screening package by the screening physician if that is the physician's customary practice. The health and developmental history component also includes the assessment of nutritional status to determine whether the child has any symptoms related to nutritional status. The history should also include a risk assessment of children/adolescents for early identification of mental health or substance abuse concerns.
33-002.02B Comprehensive Unclothed Physical Examination: This component is to be performed during each initial and periodic examination. The exam includes a physical growth evaluation and a check of the general appearance of the child to determine overall health status. Physical inspection includes a check of the organ systems.

33-002.02C Immunizations: This is to be an assessment of the immunization status determined at each screening examination and updated according to the most current immunization schedule of the Advisory Committee on Immunization Practices (ACIP) and/or American Academy of Pediatrics. Immunizations must be given at the time of the screening examination unless medically contraindicated at the time; these may be rescheduled at an appropriate time.

The Vaccine for Children Program (VFC) provides federally-purchased vaccine for most childhood immunizations for Medicaid-eligible children and adolescents 18 years old and younger. NMAP will not reimburse for a physician’s private stock vaccine when the vaccine is available through the VFC program.

Adolescents age 19 and 20 are also covered for routine preventative immunizations under the EPSDT program. Medicaid reimbursement is available for the physician’s private stock vaccine plus an administration fee for immunization of these individuals.

When a physician uses federal-purchased vaccine for immunizations, the physician must bill NMAP only for the administration. The physician must use the modifier “SL” with the vaccine code when billing for the administration. Billed charges for the administration of VFC vaccines cannot exceed the state maximum as determined by the federal VFC program. Contact the Nebraska VFC program with questions regarding the Nebraska maximum. NMAP reimburses for the administration of VFC vaccine according to the Nebraska Medicaid Practitioner Fee Schedule.

Vaccine For Children (VFC) participation is a requirement of the NHC primary care providers (PCP) providing childhood immunizations to children enrolled in an NHC health plan. Public health immunization clinics are an accessible and cost effective resource for immunizations. Contractual agreements are encouraged between managed care plans and local health departments and immunization clinics operating under the supervision of the Department of Health and Human Services, Division of Public Health. Immunization clinics must - (1) Follow the Division of Public Health protocol manual, (2) Receive vaccine, supplies, and materials from the Division of Public Health, (3) Be formally evaluated annually by the Division of Public Health, and (4) Be sponsored by a physician enrolled in the Nebraska Medicaid program. Such agreements may include provisions relating to the administration of immunizations, the administration fee reimbursement, immunization reporting requirements, and procedures for outreach and coordination of HEALTH CHECK exams and immunizations with the clinics to the plan and/or the PCP.

33-002.02D Laboratory Tests: The laboratory tests listed below are performed as appropriate for the child's age and population group as determined by the screening physician. Recommended tests are:
1. Hemoglobin/Hematocrit: A microhematocrit determination or hemoglobin concentration test from venous blood or a fingerstick according to the American Academy of Pediatrics Recommendations for Pediatric Preventive Health Care.

2. Sickle Cell: If indicated by population group. This is done with a sickle cell preparation or hemoglobin solubility test.

3. Tuberculin testing (PPD): Tuberculin testing is recommended annually for children with risk factors such as:
   a. low socioeconomic status;
   b. reside in areas where tuberculosis is prevalent;
   c. exposed to tuberculosis;
   d. immigrant status; or
   e. children with immunosuppressive conditions;

   The Mantoux test is the recommended test for screening of tuberculosis.

4. Lead toxicity screening: An assessment of risk of high-dose lead exposure and blood lead testing by either capillary or venipuncture collection method. All children ages 6-72 months of age are considered at risk for lead poisoning and must be assessed at the screening exam. Beginning at six months of age and at each visit thereafter the screening provider must assess the child’s risk for exposure. The risk assessment questions to be asked are:
   (a) Does your child live in or regularly visit a house built before 1978? Does the house have peeling or chipping paint?
   (b) Does your children live in a house built before 1978 with recent, ongoing, or planned renovation or remodeling:
   (c) Have any of your children or their playmates had lead poisoning;
   (d) Does your child frequently come in contact with an adult who works with lead (e.g. construction, welding, pottery)
   (e) Does your child live near a lead smelter, battery-recycling plant, or other industry likely to release lead?
   (f) Do you use any home or folk remedies that may contain lead?
   (g) Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
   (h) Does your home’s plumbing have lead pipes or copper with lead solder joints?
   (j) Has your child had a blood lead test in the last 12 months?

   If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure but is to receive a blood lead test at 12 months and, if possible, at 24 months.

   If the answer to any of the questions is positive, a child is considered at high risk and a blood lead test must be obtained immediately and at subsequent screening examinations. Physicians are to reference CDC guidelines for patient management and treatment.
Environmental Investigation: Locating the source of lead contamination is considered an integral part of the management and treatment of a Medicaid eligible child diagnosed with an elevated blood lead level.

Trigger: Patient specific environment investigations will be covered if the child's blood lead level is above 20 micrograms per deciliter confirmed by blood lead testing by venipuncture method and a physician must have diagnosed lead toxicity.

Site: An environmental lead investigation is an assessment of the child's home or primary residence by a health professional certified as a lead inspector using a portable x-ray fluorescence (XRF) analyzer. The investigation must also include:

1. An interview with the family to gather basic information about the habits of the child and provide information about source of lead exposure, nutritional guidelines, prevention, and clean-up advice.
2. Written recommendations to the owner of the house/apartment for the immediate and permanent removal or reduction for the lead sources.

Non-medical activities such as removal of lead sources, providing alternate housing, or analysis of samples which are sent to laboratories are not covered.

Payment: Payment will be made under an interagency contract with local or state health departments utilizing certified lead inspector at a negotiated rate that includes the initial environmental investigation and a follow-up visit, if needed.

5. Urinalysis: A rapid screening or dip test on children to detect the presence of sugar and albumin.
6. Serum Cholesterol Determination: If indicated.
7. Others: There are other tests that may be determined appropriate based on individual's age, sex, health history, clinical symptoms, and exposure to disease.

Note: When the above criteria are not met, NMAP does not cover mass screening.

33-002.02E Health Education/Anticipatory Guidance: This includes anticipatory guidance or assistance in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention to parent(s) or caretaker and child. Health education is to be part of the initial and subsequent periodic examinations. Note: Suggested guidelines are found in the most recent edition of the American Academy of Pediatrics "Guidelines for Health Supervision" or "Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents" published by the National Center for Education in Maternal and Child Health.

33-002.02F Vision Screen: Screening is to be appropriate for the child's age. Vision screening must be performed to detect problems in acuity, color blindness, and ocular alignment.
33-002.02F1 Vision Screen Within the Context of the Health Screen: Screening for visual problems for children from birth to age three may be subjective through history taking and observation. Beginning approximately age three, if the child is testable, testing is recommended at each periodic health screening according to the Recommendations for Preventive Pediatric Health Care or more often when medically indicated. Examples of appropriate testing include:

1. Examination of the external eye, and performing ophthalmoscopy on the inner eye, to assure good ocular health.
2. Visual acuity of each eye at 20 feet using a Snellen Chart, Allen Figures, Tumbling E, HOTV, Picture tests, or the equivalent.
3. Assessment of ocular alignment, which should include range of motion testing and alternate cover testing at distance and near, or the equivalent.
4. Color discrimination testing.

Referral Criteria Guidelines: Children with any ocular signs or symptoms such as blurred vision; squinting; wandering eye; crossed eye; excessive blinking; itchy, burning, or scratchy eyes; red eye or eyelid; swollen or crusted eyelid; headache if associated with reading or other demanding visual task should be referred to an optometrist or ophthalmologist. Children who fail the vision screen as listed below should also be referred to an optometrist or ophthalmologist:

1. Any abnormality of the external eye, or of internal eye as detected with the ophthalmoscope.
2. Visual acuity with a two line difference between eyes; visual acuity of 20/50 or worse in either eye for children 3-5 years old; visual acuity of 20/40 or worse in either eye for children 6 and older. (Visual acuity of 20/50 means the child cannot identify half the 20/40 figures. Visual acuity of 20/40 means the child cannot identify half the 20/30 figures. 20/40 figures are twice as big as 20/20 figures, or they are 20/20 figures just perceived at one half the distance. 20/30 figures are 1 1/2 times as big as 20/20 figures, or they are 20/20 figures just perceived at 2/3 the distance.)
3. Inability of either eye to follow a penlight through a full range of motion. Wandering, turning, or jumping of the eyes when the eyes are alternately covered while the child is carefully watching a small distant object. Wandering, turning, or jumping of the eyes when repeated while the child focuses on a small object at reading distance.
4. Failure to discriminate color is not necessarily a basis for referral, but the child and family should be counseled concerning any deficit.

33-002.02F2 Vision Screen Performed By Ophthalmologist/Optometrist: NMAP covers annual eye examinations for EPSDT participants beginning at approximately age 3. More frequent exams will also be covered if needed to determine the existence of suspected conditions. For coverage of vision services for diagnosis and treatment, see Chapter 24-000 Visual Care Services.
33-002.02G Hearing Screen: Screening is to be appropriate for the child's age. Hearing screening must be performed to detect problems in hearing loss and speech development.

33-002.02G1 Hearing Screen Within the Context of the Health Screen: Screening for hearing problems for children from birth to age three may be subjective through history-taking, observation, and use of clinical voice screening such as clapping, talking, or other noise to determine if there is a hearing problem that needs formal testing. The American Speech-Language-Hearing Association (ASHA) Guidelines for Identification Audiometry (1985, reconfirmed 1990) recommend the individualized, manual, pure tone screening at 20 decibels be conducted for each ear at test frequencies to include 1000, 2000, and 4000 Hz when in conjunction with acoustic immittance screening. If acoustic immittance is not part of the screening, 500 Hz should be added.

Referral Criteria Guidelines: ASHA states a failure to respond at the screening level to one or more frequencies in either ear is criteria for referral for further evaluation. Appropriate overall criteria for referral may be based on a failed response of 30 dB or greater in any frequency in either ear. Beginning approximately at age three, if the child is testable, audiometric screening is recommended through the use of an audiometer. Audiometric testing is recommended at health screening visits according to the Recommendations for Preventive Pediatric Health Care or more often when medically indicated.

33-002.02G2 Hearing Screen When Performed By a Licensed Audiologist: Hearing screening examinations or "routine" hearing examinations are those performed with no connection to treatment or diagnosis for a specific illness, symptoms, complaint, or injury. The examination is to follow the standards outlined by the ASHA for pure-tone screening. The hearing periodicity schedule outlines the recommended and appropriate minimum frequency for hearing screening examination (see 471 NAC 33-002.03B). More frequent exams will be covered if needed to determine the existence of suspected problems. Hearing screening examinations or "routine" hearing examinations for EPSDT participants do not require prior authorization for payment. For coverage of hearing services for diagnosis and treatment, see Chapter 23-000, Speech Pathology and Audiology Services.

33-002.02H Dental Screening: The dental screening examination is to be performed to detect deterioration of hard tissues and inflammation or swelling of soft tissues. For very young children, this may be performed by a visual inspection of the palate and dental ridge as part of the health screening examination. A direct referral to a dentist is required beginning at age one as indicated on the health screening periodicity schedule (see 471 NAC 33-002.03A) or earlier if determined medically necessary. Thereafter, dental screening examinations at six-month intervals are recommended. More frequent dental examinations will also be considered appropriate to determine the existence of suspected conditions. Dental screening examinations for EPSDT participants do not require prior authorization for payment. For coverage of dental services for diagnosis and treatment, see 6-000, Dental Services.
33-002.03 Periodicity Schedules: The following schedules provide a minimum basis for follow-up assessments after the initial examination to ensure continued health and well-being and to detect conditions requiring treatment. Wards of the Department may be screened each time they are placed in a foster home or facility. Physical examinations may be performed when necessary for school, camp, or similar activity.

33-002.03A Health Screening Periodicity Schedule: "Recommendations For Preventive Pediatric Health Care" published by the American Academy of Pediatrics (most recent version) is considered the minimum guidelines for health screening examinations.

33-002.03B Hearing Screening Periodicity Schedule:

Birth to 3 years
Screening through history taking, observation, and clinical voice screening at intervals that follow the Health Screening periodicity schedule.

Age 3 years to 21 years
Screening by standard testing method yearly or according to the Health Screening periodicity schedule. (Others allowed - see 471 NAC 33-002.04, Interperiodic Screening.)

33-002.03C Dental Screening Periodicity Schedule:

Birth to 21 years
At six month intervals, dental screening is to be obtained from a dentist beginning at age one or earlier if medically necessary. Visual inspection of the mouth for very young children is recommended as part of each Health Screening examination. (Others allowed - see 471 NAC 33-002.04, Interperiodic Screening.)

33-002.03D Vision Screening Periodicity Schedule:

Birth to 3 years
Screening through history taking and observation at intervals that follow Health Screening periodicity schedule.

Age 3 years to 21 years
Screening by standard testing method yearly or more frequently if medically necessary. (Others allowed - see 471 NAC 33-002.04, Interperiodic Screening.)

33-002.04 Interperiodic Screening: Interperiodic screening examinations, performed outside of the periodicity schedule, will be covered when medically necessary to determine the existence of suspected physical or mental illnesses or conditions or if the severity of an illness or condition has changed. The determination of whether an interperiodic screening is medically necessary may be made by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system. Note: If the minimum components of a periodic health screening as defined in 471 NAC 33-002.02 are not performed, and only illness care is provided, the service should be reported and claimed on the appropriate professional claim form or electronic format (see Claim Submission Table at 471-000-49) as an acute care service. These visits require that a complete HEALTH CHECK screen be done (components A-E).
**33-002.05 Interagency Agreements:** The HEALTH CHECK (EPSDT) program shall coordinate with other programs that provide health services to children as provided in 42 CFR 441.61 and State Medicaid Manual, Part 5, Section 5230. Interagency collaborative activities address several goals simultaneously:

1. Containing costs and improving services by reducing service overlaps or duplications, and closing gaps in the availability of services;
2. Focusing services on specific population groups or geographic areas in need of special attention; and
3. Defining the scope of the programs in relation to each other.

Examples of agencies for which interagency agreements would be appropriate are public health programs, Head Start, and school districts. The interagency agreement may include HEALTH CHECK (EPSDT) services, such as outreach and referral, notification, support services, health care services, and/or follow-up services.

**33-002.06 Continuing Care Providers:** Continuing care is the provision of HEALTH CHECK (EPSDT) preventive, acute, and chronic care services by a single provider, who coordinates care, maintains a consolidated medical record of the child, and is the child's regular source of health care. A continuing care provider is one who -

1. Agrees to provide to formally enrolled children screening, diagnosis, and treatment for conditions identified during screening or referral to a provider capable of providing the appropriate services;
2. Maintains a complete health history, including information received from other providers;
3. Is responsible for providing needed physician services for acute, episodic, and/or chronic illnesses and conditions;
4. Ensures accountability by submitting reports reasonably required by NMAP; and
5. Works with the EPSDT case manager, if one is assigned.

As appropriate, the formal enrollment means that the EPSDT-eligible child or family has agreed to use one provider as a regular source of continuing care services for a stated period of time, and that mutual obligations of both client and provider are recognized by signed enrollment agreement.

The continuing care agreement must specify what options the provider will use to provide the following HEALTH CHECK (EPSDT) services:

1. Provision of dental services, or direct referral to a dentist or referral to the local HHS Office to obtain dental services;
2. Provision of all or part of the required transportation and scheduling assistance, or referral to local HHS Office to obtain such assistance; and
3. Referral assistance for treatment not covered by the plan but needed, or referral to local HHS Office to obtain assistance as well as other provisions outlined in the agreement.

Managed care plans will be considered continuing care providers if these provisions are met.
33-002.07 Payment for HEALTH CHECK (EPSDT) Services: Nebraska Medicaid pays for covered HEALTH CHECK services, except for clinical laboratory services or when provided under capitated contract for EPSDT participants enrolled in capitated plans, at the lower of:

1. The provider’s submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost;
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Payment for clinical laboratory services is at the amount allowed for each procedure code in the fee schedule for clinical laboratory services as established by Medicare.

The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation;

Providers will be notified of the revisions and their effective dates.

33-002.08 Billing Requirements: Providers shall bill Medicaid on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for HEALTH CHECK (EPSDT) exams, HEALTH CHECK-associated services, and other comparable exams. See Claim Submission Table at 471-000-49.

Note: Providers are to bill all well-baby, well-child exams, and comparable examinations as HEALTH CHECK examinations.

The physician or the physician’s authorized agent submit the physician’s usual and customary charge for each procedure code listed on or in the claim.
33-002.08A Procedure Codes: Physicians shall use HCPCS procedure codes when submitting claims or encounter data to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

1. Level 1: The codes contained in the most recently published edition of the American Medical Association's Current Procedural Terminology (CPT); and
2. Level 2: Federally-defined alpha-numeric codes.

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518 and 533.)

33-003 HEATH CHECK (EPSDT) Special Services: The following services are covered to prevent, correct, or ameliorate a disease or condition identified during a screening examination and reported on the HEALTH CHECK claim form or electronic format. These services are considered part of the EPSDT benefit and are available to Medicaid-eligible individuals under 21.

All special service providers must be licensed Medicaid-enrolled providers who have submitted written required documentation and received written approval from the Medicaid Division. All providers requesting to provide HEALTH CHECK special services must submit a request in writing. All written information pertaining to provider requests or approval should be submitted to the Medicaid HEALTH CHECK program specialist at P.O. Box 95026, Lincoln, NE 68509. Any additional provider requirements for approval to provide special services and receive reimbursement are detailed in the following service sections. All approved providers must complete and submit a "Medical Assistance Provider Agreement," Form MC-19. Payment for services is according to NMAP Practitioner Fee Schedule unless included as part of a capitated plan. For HMO enrollees, providers of these services must obtain a referral or authorization from the PCP to receive payment. See the Claim Submission Table at 471-000-49 for billing instructions.

Approval to provide special services for Medicaid reimbursement is granted in writing by the Medicaid Division. Payment for special services is made according to the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-533) unless included as part of a capitation plan. Instructions for billing will be included with the written approval. The Medicaid Division may also withdraw a provider’s approval by written notification to the provider if the provider no longer meets the following identified requirements.

33-003.01 Nutritional Counseling: This service involves short term (one to four sessions per medical home referral) one-on-one nutritional counseling sessions. This does not include group sessions, which may be covered through weight management services (see 471 NAC 33-006). The child’s condition must indicate that a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.
Nutritional problems or conditions that are considered appropriate for nutritional counseling are:

1. Chronic gastrointestinal tract problems, such as chronic constipation, colitis, liver dysfunctioning, ulcers, tumors, gastroesophageal reflux, malabsorption disorders or chronic diarrhea associated with nutrient loss, short bowel syndrome, or celiac disease;
2. Chronic cardiovascular problems, blood and renal, such as kidney failure, heart disease, or renal failure hypertension;
3. Metabolic disorders, such as diabetes, electrolyte imbalance, cystic fibrosis, disorders of lipid metabolism, or in-born errors of metabolism, such as phenylketonuria (PKU);
4. Malnutrition problems, such as protein, mineral, vitamin, and energy deficiencies, failure to thrive, anorexia nervosa, or bulimia; and
5. Other problems and conditions, such as food allergy and/or intolerance, anemias, pregnancy, drug-induced dietary problems, nursing bottle mouth syndrome, obesity, inadequate or inappropriate techniques of feeding, inadequate or excessive weight gain, neoplasms, or cleft palate or cleft lip.

This is not an all inclusive list. Other conditions may be appropriate for this service and approved upon review by the Medicaid Division. This service does not include long term nutritional counseling for eating disorders (see 471 NAC 32).

For ongoing nutritional information for individuals meeting certain criteria (children under five lactating, postpartum, or pregnant women), a referral must be made to the Special Supplemental Food Program for Women, Infants, and Children (WIC).

33-003.01A Provider Requirements and Requests for Approval: Physicians providing HEALTH CHECK (EPSDT) services or licensed medical nutrition therapists may be approved to provide nutritional counseling. Those who are interested in providing this service shall submit a written request and include (1) person(s) providing services and their credentials, (2) general content of nutritional counseling session, (3) conditions most frequently expected to be encountered, (4) usual length and frequency of sessions, and (5) customary charge. NMAP may request periodic review of the services. Requests for reapproval must be submitted when a change in approved content occurs.

For ongoing nutritional counseling for individuals meeting certain criteria (children under five; lactating, postpartum, or pregnant women), a referral must be made to the Special Supplemental Food Program for Women, Infants, and Children (WIC).

33-003.02 Risk Reduction Services for EPSDT Participants: An EPSDT participant is an individual who has had a HEALTH CHECK screening examination and therefore considered a program participant.

33-003.02A Prepared Childbirth Sessions: The basic six to eight week series of childbirth sessions, early pregnancy sessions, refresher sessions, cesarean birth sessions, breastfeeding session, and infant care sessions are covered when provided by licensed and Medicaid-enrolled practitioners approved by the Medicaid Division. The services are covered when a comparable community service is not readily available at no cost.
Childbirth educators who are licensed practitioners interested in providing this service for Medicaid-eligible individuals age 20 and younger shall complete Form MC-19, "Medical Assistance Provider Agreement," and return the form with a letter stating the class type, general description, class outline, or statement of content, and length of sessions for initial approval. Childbirth educators must include proof of certification or course completion by a recognized childbirth education association. Requests for reapproval must be submitted when a change in the initial proposal occurs. NMAP may request periodic review of the services. Requests to approve changes to approved services must be submitted to the Medicaid Division. Approval is based on guidelines from recognized childbirth education associations and demonstrate appropriateness.

Risk reduction services are:

- Family home visitation for risk assessment and risk reduction services
- Health education and infant-child care/parenting session or breast-feeding instruction session
- Early pregnancy session
- Prepared childbirth session (six-eight week series) or comparable cesarean birth session
- Prepared childbirth refresher series

33-003.02B Pediatric Prenatal Visit: The pediatric prenatal visit is a scheduled visit to initiate and set the tone for a working relationship between the expectant parent(s) and the prospective primary care provider of the infant's health care. This is usually scheduled in the last trimester of the pregnancy. The purpose is to gather medical information, give information, answer questions, and initiate a continuing relationship in the best interest of the child. It provides the opportunity to establish a supportive, positive relationship based on mutual respect. Other benefits include the chance to discuss the benefits of early and regular health care, of appointment-keeping, and utilizing the most appropriate place of service. A prenatal visit usually includes a maternal and family health history and related data gathering, preparation of parent(s) for hospital birth information on breast-feeding vs. bottle feeding, information on infant care, information on parenting classes, preparation for potential changes in family and sibling relationships with birth, information on effects of drugs and medications on pregnancy and nursing infants, discussion on preparation for home care and home safety, information on well baby care, information on choosing child care, and office philosophy and practices.

33-003.03 Well Child Cluster Visit: The cluster visit is a well child visit in a group setting with parent-child pairs of similar age offering the opportunity for the provision of extended physician-parent/child time with a focus on psychosocial aspects as well as physical aspects of well child care. Cluster visits are covered for infants and children, according to the American Academy of Pediatric schedule for examinations. The cluster visit must include a complete HEALTH CHECK (EPSDT) examination. The parent may opt for this service instead of the individual visit for the parent(s).

Providers interested in providing this service shall submit a description of the cluster visit, including format, group size, scheduling, and content to the Medicaid Division to request initial prior approval. Requests to approve any changes to the approved service must be submitted to the Medicaid Division.
33-004 Dental Services for Conditions Identified During a HEALTH CHECK

33-004.01 Orthodontic Treatment: NMAP covers orthodontic treatment for individuals age 20 and younger for treatment of handicapping malocclusions. NMAP requires prior authorization of orthodontic treatment except diagnostic evaluation procedures. NMAP regulation regarding orthodontic treatment is in Chapter 6-000.

33-005 (Reserved)
34-000 RURAL HEALTH CLINICS (RHC’s)

34-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), a Rural Health Clinic must be certified by the Centers for Medicare and Medicaid Services (CMS) for participation in the Medicare program.

34-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

34-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;
2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and
3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed according to the Nebraska Medicaid Practitioner Fee Schedule.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider must provide services only under arrangement with the HMO.

34-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider must obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and
2. Abortions: As currently defined, abortions require prior authorization by NMAP.
34-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP must authorize the services to be provided by the approved provider as needed with the following exceptions:

1. **Visual Care Services**: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers must contact the client’s PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner must send a written summary of the client’s condition and treatment/follow-up provided, planned, or required to the client’s PCP.

2. **Dental Services**: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 must bill that service on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837), using CPT procedure codes. These services require referral/authorization from the client’s PCP. The provider shall contact the PCP before providing these services. If a client requires hospitalization for these services, the provider must contact the PCP for referral/authorization.

3. **Family Planning Services**: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

34-002.03 Mental Health and Substance Abuse Services: Mental health and substance abuse services (MH/SA) are provided through the MH/SA managed care plan for all NHC clients. The plan includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization from the plan. All other MH/SA services must be prior authorized as directed by the plan.
Covered RHC Services: NMAP covers services provided by RHC's on or after July 1, 1990, under this chapter. NMAP defines covered Rural Health Clinic services as the following services provided by a Certified Rural Health Clinic:

1. Services provided by a physician within the scope of practice under state law, if the physician performs the services in the clinic or the services are provided away from the clinic and the physician has an agreement with the clinic provided that s/he will be paid by the clinic for the services;
2. Services provided by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner if the services are provided in accordance with Medicare requirements;
3. Services and supplies that are provided as an incident to professional services provided by a physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner;
4. Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if -
   a. The clinic is located in an area in which the Centers for Medicare and Medicaid Services has determined that there is a shortage of home health agencies;
   b. The services are provided by a registered nurse or licensed practical nurse or a licensed vocational nurse who is employed by, or otherwise compensated for services by the clinic;
   c. The services are provided under a written plan of treatment that is established and reviewed at least every 60 days by a physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner and review and approved at least every 60 days by a supervising physician of the clinic; and
   d. The services are provided to a "homebound" client. For the purposes of visiting nurse care, a "homebound" client is one who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. The client may be considered homebound if the client leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or skilled nursing facility.
34-004 Payment for Rural Health Clinic Services: NMAP will pay for services provided by Rural Health Clinics in compliance with Section 1902 (bb) of the Social Security Act. The Department assures that payments to all RHCs will result in a payment to the clinic in the amount which is at least equal to the Prospective Payment System.

34-004.01 Definitions means the following definitions apply within this chapter:

**Encounter** means a face-to-face visit between a Medicaid-eligible patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

**Encounter Payments** means PPS rate paid to the RHC by the Department multiplied by the number of encounters billed.

**Encounter Rate** means the all-inclusive PPS rate that the Department reimburses the RHC for an encounter.

**Independent Rural Health Clinic** means A clinic that is free standing with no association to a hospital, nursing facility, or home health agency.

**Medicare Cost Report** means the report filed by each RHC provider with its Medicare intermediary as required by Chapter 9 of the Medicare Rural Health Clinic and Federal Qualified Health Center Manual.

**Prospective Payment System (PPS)** means the payment system where in a reimbursement rate is paid for services provided.

**Provider-Based Rural Health Clinic** means a rural health clinic that is an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed and supervised by the facility.
34-005 Prospective Payment System

34-005.01 Payment for Services Provided by Provider-Based Rural Health Clinics Associated with Hospitals Having 50 Beds or Greater: The Department will compute the Prospective Payment System (PPS) base rate as follows:

1. Combine reasonable costs from the RHC fiscal year 1999 and 2000 cost reports; then
2. Divide the cost by the combined Total Adjusted Visits from the two fiscal year cost reports (Form CMS-222-92 Worksheet C, Part 1, Line 6; or Form CMS-2552-96 Worksheet M-3, Line 6).

Effective October 1, 2001, the Department will update the PPS base rate annually using the Medicare Economic Index (MEI).

34-005.02 Payment for Services Provided by Provider-Based RHCs Associated with Hospitals Having Less Than 50 Beds: NMAP pays for RHC services provided by provider-based clinics that are associated with hospitals of less than 50 beds at the lower of cost or charges as established by Medicare.

34-005.03 Payment for Services Provided by Independent Rural Health Clinics (IRHCs): The Department will compute the PPS base rate for IRHCs as follows:

1. Combine reasonable costs from the RHC fiscal year 1999 and 2000 cost reports; then
2. Divide the cost by the combined total adjusted visits from the two fiscal year cost reports.

Effective October 1, 2001, the Department will update the PPS base rate annually using the Medicare Economic Index (MEI).

34-005.04 Rates for New RHCs: The Department will establish rates for a new RHC entering the program after 1999 as follows:

1. For the initial year, the interim rate will be an average of the PPS rate of all RHCs in Nebraska. The interim rate will be retroactively settled based on the RHC’s initial cost report.
2. The RHC’s individual PPS base rate will be computed using its initial cost report.
3. Once the PPS base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI).
34-005.05  RHC Managed Care Payment:  RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payment the RHC receives from the MCE(s) and the payments the RHC would have received under the PPS methodology or payments as established under Section 34-005.02 for those RHC receiving payment as a provider based RHC associated with hospitals having less than 50 beds.

34-005.05A  At the end of each RHC fiscal year, for each Independent RHC and Provider based RHC associated with hospital of 50 or more beds the Department will compare:

1. The total amount of supplemental and MCE payments received by the RHC; to
2. The amount that the actual number of visits provided under the RHC's contract with the MCE(s) would have yielded under the PPS methodology.

The Department will pay the RHC the difference between item 1 and item 2 if the PPS amount exceeds the total amount of supplement and MCE payments. The RHC must refund the difference between item 1 and item 2 if the PPS payment is less than the total amount of the supplemental and MCE payments.

34-005.05B  At the end of each RHC fiscal year for Provider based RHC associated with hospital having less than 50 beds, the Department will compare:

1. The total amount of the supplemental and the MCE(S) payments received by the RHC
2. The amount that the clinic would have received as payment under section 34-005.02.

The Department will pay the RHC the difference between item 1 and 2 if the actual amount exceeds the total amount of supplement and MCE payments. The RHC must refund the difference between item 1 and item 2 if the actual payment is less than the supplemental and MCE payments received by the RHC.

34-006  Payment for Non-RHC Services:  For those non-RHC services, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

34-007  Payment for Telehealth Services:  Payment for telehealth services will be the Medicaid rate for the comparable in-person service. RHC core services provided via telehealth technologies are not covered under the encounter rate.

34-007.01  Payment for Telehealth Transmission Costs:  Payment for telehealth transmission costs related to non-core services will be the lower of:

1. The provider’s submitted charge; or
2. The maximum allowable amount.
The Department will pay for transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmissions (see 471 NAC 1-006).
34-008 Cost Reports: Providers participating with NMAP as RHCs must submit an annual cost report to the Department. The RHC must report and supply the Department with necessary documentation regarding, cost reports, and any other documentation when requested.


34-009 Billing for RHC Services: All RHCs must bill for Rural Health Services as defined in 471 NAC 34-003 on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). RHCs will use the appropriate HCPCS/CPT procedure codes and revenue codes when billing for all services.

IRHCs must use Form CMS-1500 (see 471-000-58) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) to bill NMAP for clinical radiology/laboratory services using the non-Rural Health Clinic provider number.

All Provider-Based RHCs must use Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) to bill NMAP for clinical laboratory services and radiology services using the hospital provider number.
CHAPTER 35-000 REHABILITATIVE PSYCHIATRIC SERVICES

35-001 Introduction: The Nebraska Medical Assistance Program (NMAP) covers rehabilitative psychiatric services to rehabilitate clients experiencing severe and persistent mental illnesses in the community and thereby avoid more restrictive levels of care such as inpatient psychiatric hospital or nursing facility. Rehabilitative psychiatric services for children age 20 and younger are covered under EPSDT treatment plans, as described in Chapter 32-000 of this Title. Rehabilitative psychiatric services for adults age 21 and older are covered under the rules and regulations of this chapter. The services must be medically necessary and the most appropriate level of treatment for the individual client. This does not include treatment for a primary substance abuse diagnosis.

35-001.01 Definition of Severe and Persistent Mental Illness: Clients with severe and persistent mental illness must meet the following criteria:

1. The client is age 21 and over;
2. The client has a primary diagnosis of schizophrenia, major affective disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Developmental disorders, or psychoactive substance use disorders may be included if they co-occur with the primary mental illnesses listed above;
3. The client has a persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client’s ability to function independently in an appropriate and effective manner in two of three functional areas: Vocational/Education, Social Skills, Activities of Daily Living.
   a. Functional limitations in the area of Vocational/Education abilities are defined as:
      (1) An inability to be consistently employed or an ability to be employed only with extensive supports, except that a person who can work but is recurrently unemployed because of acute episodes of mental illness is considered vocationally impaired;
      (2) Deterioration or decompensation resulting in an inability to establish or pursue educational goals within a normal time frame or without extensive supports;
      (3) An inability to consistently and independently carry out home management tasks, including household meal preparation, washing clothes, budgeting, and child care tasks and responsibilities;
   b. Functional limitations in the area of Social Skills and abilities are defined as:
      (1) Repeated inappropriate or inadequate social behavior or an ability to behave appropriately or adequately only with extensive or consistent support or coaching or only in special contexts or situations, such as social groups organized by treatment staff; or
      (2) Consistent participation in adult activities only with extensive support or coaching and when involvement is mostly limited to special activities established for persons with mental illness or other persons with interpersonal impairments; or
      (3) A history of dangerousness to self or others.
c. Functional limitations in the area of Activities of Daily Living are defined as an inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community, in three of five areas listed below:
   (1) Grooming, hygiene, washing of clothes, and meeting nutritional needs;
   (2) Care of personal business affairs;
   (3) Transportation and care of residence;
   (4) Procurement of medical, legal, and housing services; or
   (5) Recognition and avoidance of common dangers or hazards to self and possessions.

4. The client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for one year or longer and is likely to endure for one year or longer; and

5. The client does not have a primary diagnosis of substance abuse/substance dependency or developmental disabilities.

35-001.02 Definition of Medical Necessity: The NMAP uses the following definition of medical necessity:

"Health care services and supplies which are medically appropriate and -

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

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered."

For purposes of covering rehabilitative psychiatric services under this Chapter, the following interpretative notes apply. Medical necessity for rehabilitative psychiatric services includes:
Health care services which are medically appropriate and -

1. Necessary to meet the psychiatric rehabilitation needs of the client;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of service with accepted principles of psychiatric rehabilitation;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her service provider(s);
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. A no more intense level of service than can be safely provided.

For the purpose of this Chapter, rehabilitative psychiatric services are medically necessary when those services can reasonably be expected to increase or maintain the level of functioning in the community of clients with severe and persistent mental illness.

35-002 Provider Participation: To participate in NMAP as a provider of rehabilitative psychiatric services, a program must be certified by the Department of Health and Human Services under the applicable rules and regulations described in 204 NAC. The provider shall agree to contract with the Department of Health and Human Services for the provision of rehabilitative psychiatric services, and demonstrate the capacity to fulfill all the contractual requirements contained therein. The provider must also complete and sign Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and be approved for enrollment in NMAP. In addition, eligible providers must also provide other documentation requested.

35-003 Nebraska Health Connection Services: Certain Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program (known as the Nebraska Health Connection). The Department developed the NHC to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State. The NHC was implemented on July 1, 1995. Enrollment in the NHC is mandatory for certain clients in designated geographic areas of the state. NHC clients will receive a Nebraska Medicaid Identification Card. Participation in NHC can be verified by accessing the Department Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580) (see 471-000-124); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or electronically using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

The NHC utilizes two models of managed care plans to provide the basic benefits package; these models are health maintenance organizations (HMO's) and primary care case management (PCCM) networks. The NHC also provides a mental health and substance abuse benefits package on a statewide basis available to all clients who are required to participate in NHC.

If a client is required to participate in the NHC, all services contained in the benefits package (MH/SA or medical) must be provided under the management of the managed care plan.
35-004 Covered Services: Medicaid covers the following rehabilitative psychiatric services under the rules and regulations of this chapter:

1. Community Support;
2. Day Rehabilitation;

For the purposes of meeting the requirements of 471 NAC 35-002, programs certified by the Department of Health and Human Services under 204 NAC 5 (effective date December 19, 1994) as Residential Support and/or Service Coordination providers shall be considered to be certified as Community Support providers.

35-004.01 Community Support: The Community Support program is designed to:

1. Provide/develop the necessary services and supports to enable clients to reside in the community;
2. Maximize the client’s community participation, community and daily living skills, and quality of life;
3. Facilitate communication and coordination between mental health rehabilitation providers that serve the same client; and
4. Decrease the frequency and duration of hospitalization.

Community support shall provide client advocacy, ensure continuity of care, support clients in time of crisis, provide/procure skill training, ensure the acquisition of necessary resources, to assist clients with spend downs and other financial insurance coverage programs and assists the client in achieving community/social integration. The community support program shall provide a clear focus of accountability for meeting the client's needs within the resources available in the community. The role(s) of the community support provider may vary based on client's needs. Community support is a service in which the client’s contact occurs outside the program offices in community locations consistent with the individual client choice/need. Community support is frequently provided in the home and is not facility or office-based. Ninety-day treatment, rehabilitation and recovery team meetings are not considered to be a community support service. The frequency of contact between the community support provider and the client is individualized and adjusted in accordance with the needs of the client.

Prior to admission to a community support program, an Initial Diagnostic Interview shall be completed by an independently licensed practitioner (psychiatrist, psychologist, or LIMHP). The purpose of this assessment is to determine/verify the presence of a severe and persistent mental illness which requires psychiatric rehabilitation services. The document must include the need of the specific rehabilitation services necessary to meet the treatment and recovery goals of the client.

Community Support is a separate and distinct service, and may not be provided as a component of other Rehabilitative Psychiatric Services or Mental Health Outpatient Services. Agencies that provide more than one level of rehabilitative psychiatric or Mental Health Outpatient service shall have staff dedicated to the Community Support program. These Community Support staff shall not provide any other rehabilitative psychiatric or treatment service to the client.
35-004.01A Program Components: The Community Support program shall –

1. Facilitate communication and coordination among the mental health rehabilitation providers serving the client;

2. Ensure that the client has a diagnosis of severe and persistent mental illness, as exhibited by the completion of an Initial Diagnostic Interview, no more than 12 months prior to admission to Community Support. The Initial Diagnostic Interview must identify the need for Community Support and outline the needed services and resources for the client.

3. Ensure completion of a strength-based needs assessment which may include skills inventories, interviews and other tools to develop treatment and rehabilitation plans which must be completed within 30 days of admission by the rehabilitation team or team members.

4. Ensure the completion of an Individual Treatment, Rehabilitation, and Recovery Plan for each client served. The Individual Treatment, Rehabilitation, and Recovery Plan shall be completed within 30 days following the admission of the client and reviewed and updated every 90 days or as often as clinically necessary thereafter while receiving services. The Individual Treatment, Rehabilitation, and Recovery Plan shall be based on the results of comprehensive assessments and is developed with the client’s involvement and through an interdisciplinary team process. The Individual Treatment, Rehabilitation, and Recovery Plan shall include methods and interventions to address: activities of daily living, community living skills, budgeting, education, independent living skills, social skills, interpersonal skills, psychiatric emergency/relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, physical health care, vocational/educational: services, resource acquisition, and other related areas as necessary for successful living in the community.

5. Ensure the Individual Treatment, Rehabilitation, and Recovery Plan that encompasses the supportive/rehabilitative interventions that will be directly provided by the Community Support Program;

6. Identify the provision of services/interventions identified in the Individual Treatment, Rehabilitation, and Recovery Plan as the responsibility of other rehabilitative service providers;

7. Develop and implement strategies to assist the client in becoming engaged and remaining engaged in medically necessary mental health treatment and psychiatric rehabilitation services;

8. Provide service coordination and case management activities, including coordination or assistance in accessing medical, social, education, housing, transportation or other appropriate support services as well as linkage to other community services identified in the Individual Treatment, Rehabilitation, and Recovery Plan.

9. Facilitate communication between the treatment and rehabilitation providers and with the primary care physician/psychiatrist serving the client.

10. Monitor client progress of the services being received and participate in the revision of the Individual Treatment, Rehabilitation, and Recovery Plan as needed or at the request of the client;
11. Provide contact as needed with other service provider(s), client family member(s), and/or other significant people in the client’s life to facilitate communication necessary to support the individual in maintaining community living;

12. Assist the client in the developing, evaluating and updating a crisis and relapse prevention plan. This plan shall be coordinated with any other rehabilitative service and include the client’s natural supports. Provide therapeutic support and intervention to the client in time of crisis. If hospitalization is necessary, facilitate, in cooperation with the inpatient treatment provider, the client’s transition back into the community upon discharge;

13. Participate with and report to the treatment/rehabilitation team on the progress of the client in areas of medication compliance, relapse prevention, social skill acquisition, application, education, substance abuse, and ability to sustain community living.

14. Monitor medication compliance; and

15. Assist the client with all health insurance issues including Share of Cost eligibility issues. Ensures client understanding of financial benefits and procedures to use those benefits such as Medicaid spend downs, AABD, SSI and SSA, etc.

35-004.01B Admission and Discharge Criteria for Community Support Services

35-004.01C Admission Criteria: Community Support Services shall be prior authorized by the Division of Medicaid and Long-Term Care or its designee. To be eligible for Community Support Services, the client shall meet all of the criteria described in 471 NAC 35-001.01 and the Community Support specific criteria identified by this prior authorization process.

35-004.01D Staffing Requirements: Rehabilitative programs shall provide staff to deliver rehabilitative psychiatric services and staff may be either licensed practitioners operating within their scope of practice or skilled direct care staff that shall meet the following minimum standards:

1. Have demonstrated skills and competencies in working with people experiencing severe and persistent mental illness;

2. Have completed a staff training curriculum for initial orientation and completes a continuing education curriculum at intervals as defined and prepared by the providing agency. This curriculum and periodic updates shall be included in the program description submitted to the Division of Medicaid and Long-Term Care;

3. Licensed staff provide services as identified within their scope of practice; and

4. All staff are trained in the principles of recovery.
35-004.01E Clinical Staff: The Community Support program shall have available a:

1. **Licensed Clinical Supervisor**: The clinical supervisor shall qualify as a licensed practitioner and shall participate in the Individual Treatment, Rehabilitation, and Recovery Plan development and provide clinical supervision, consultation, and support. The Licensed Clinical Supervisor will review community support client's clinical needs and progress toward their goals with the community support worker every 30 days. The review should be completed preferably face-to-face. The review may be accomplished by the supervisor consulting with the community support worker on their assigned clients and providing clinical guidance or recommendations to better serve the client.

2. **Other Consultants**: Consultation by licensed professionals for general medical, psychopharmacology, and psychological issues, as well, as overall program design and shall be available and accessed as necessary.

35-004.01F Direct Care Staff: The Community Support program shall have Community Support staff who:

1. Direct Care staff having a bachelor's degree in psychology, sociology or related human services field or two years of course work in the human services field and two years of experience/training in the human services field or two years of lived recovery experience is acceptable. All community support workers shall be trained in rehabilitation and recovery principles and shall have demonstrated skills and competency. Each staff shall have demonstrated skills and competency in treatment with individuals with mental health diagnosis.

Direct care staff employed by an agency before the effective date of these regulations will be considered to meet staffing requirements when the provider submits documentation identifying the name, address and the provider number, service provided, names of direct care staff employed before the effective date of the these regulations, and their date of hire. Documentation shall be submitted to Medicaid within 30 days following the effective date of these regulations. Staff hired on or after the effective date of these regulations shall meet the specified requirements identified in the above paragraph;

2. Receive monthly supervision by the Community Support Clinical Supervisor.

35-004.02 Program Availability: The Community Support Program shall establish hours of service delivery that ensure program staff are accessible and responsive to the needs of the client. Scheduled services shall include evening and weekend hours. The Community Support Program shall directly provide or otherwise demonstrate that each client has on-call access to a licensed mental health practitioner on a 24 hour, 7 days per week basis. Access to a licensed mental health practitioner shall be documented in the client's Individual Treatment, Rehabilitation, and Recovery Plan.
35-004.03 Contacts: The frequency of contact between the client and the Community Support worker shall be individualized and adjusted in accordance with the needs of the client. Community Support providers shall ensure that the amount of direct contact is sufficient to meet the client’s needs as identified in the Individual Treatment, Rehabilitation, and Recovery Plan. Contacts may either be direct client contact or collateral contact.

1. Direct Client Contact. Direct client contacts are face-to-face services between the community support worker and the client. Direct contacts with the client that focus on the development of skills or the management of other activities are identified on the Individual Treatment, Rehabilitation, and Recovery Plan. Contacts shall occur in community settings and be medically necessary for the client’s recovery. Face to face contact shall be individualized to the client’s recovery needs and shall be identified in the client’s Individual Treatment, Rehabilitation, and Recovery Plan in anticipated occurrences. Face to face contacts shall be calculated in 15 minute increments up to a maximum of 144 units per 180 days. In situations of client absence or unavailability for a scheduled contact, providers shall document the circumstances in which the scheduled face-to-face contact did not occur and the program’s response to the lack of clients availability to participate in the community support intervention.

2. Collateral Contact. Collateral contacts are defined as contacts which occur outside the provider organization without the client present and are related to the client’s Individual Treatment, Rehabilitation, and Recovery Plan. Collateral contacts shall be documented in the client's clinical record and are considered an essential supportive component to the client's treatment, recovery and rehabilitation plan but may not be billed as a separate service to Medicaid.

35-004.04 Clinical Documentation: Rehabilitative psychiatric service providers shall maintain a clinical record that is confidential, complete, accurate, and contains up-to-date information relevant to the client’s care and services. The record shall sufficiently document assessments, Individual Treatment, Rehabilitation, and Recovery Plans and plan reviews, and important provider discussion. The clinical record shall document client contacts describing the nature and extent of the services provided, such that a clinician unfamiliar with the service can identify the client’s service needs and services received. The documentation shall reflect the rehabilitative services provided, and is consistent with the goals in the treatment and recovery plan, and based upon the comprehensive assessment. The absence of appropriate, legible, and complete records may result in the recoupment of previous payments for services. Providers shall provide the clinical record in the English language, however, providers shall accommodate clients of other cultures and language in order that the client can completely participate in and understand their treatment and recovery rehabilitation program. Each entry shall identify the date, beginning and end time of the service and the location of service. The individuals in attendance shall be identified by name and relationship to the identified client and the name and title of the staff person providing the intervention and entering the information.
Clinical records shall be maintained at the provider's headquarters. Records shall be kept in a locked file when not in use. For purposes of confidentiality, disclosure of treatment information is subject to all the provisions of applicable State and Federal laws. The client's clinical record shall be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason shall be documented in the clinical record and reviewed periodically.

35-004.04A The clinical record shall include, at a minimum:

1. Client identifying data, including demographic information and the client's legal status;
2. Assessment and Evaluations;
   a. Initial Diagnostic Interview completed prior to admission;
   b. Strength-based needs assessment;
   c. Other appropriate assessments.
3. Treatment and Recovery Plan and updates to plans;
4. Documentation of review of Client Rights with the client;
5. A chronological record of all services provided to the client. Each entry shall include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service (beginning and end time), the place of the service, and the staff member's identity and legible signature, (name and title);
6. Documentation of the involvement of family and significant others;
7. Documentation of treatment and recovery services and discharge planning;
8. A chronological listing of the medications prescribed (including dosages and schedule) for the client and the client's response to the medication;
9. Documentation of coordination with other services and treatment providers;
10. Discharge summaries from previous levels of care;
11. Discharge summary (when appropriate); and
12. Any clinical documentation requirements identified in the specific service.

35-004.05 Provider Participation: To participate as a Medicaid provider of psychiatric community support, the provider shall be enrolled as a provider of services according to Medicaid regulations. Providers shall contact the Medicaid Managed Care entity to credential into its network. The provider shall provide updates to the program information and staffing as necessary. The provider shall sign an agreement at the time of enrollment that states the provider will submit initial and annual cost information to Medicaid as a part of the enrollment. The cost information shall be updated upon request.

Community support providers shall be appropriately licensed when licensure is required to provide the service and the program shall have acquired national accreditation in JCAHO, CARF or COA as a condition for enrollment as a participating provider. Accreditation shall be maintained throughout the Medicaid participation period.
35-004.06 Clients’ Rights: Individual staff and the treatment and recovery team shall provide all services in a manner to support and maintain the client’s rights with a continuous focus on client empowerment and movement toward recovery. Providers shall have written Client Rights and Responsibility policy and staff shall review client rights, responsibilities, and grievance procedures with each new client at admission, at treatment and recovery plan review and at the request of the client. This review shall be documented in the clinical record. Substance Abuse Treatment providers shall comply with all State and Federal Clients’ Rights requirements.

Client rights shall be observed when receiving substance abuse services through Medicaid. The client has the right to:

1. Be treated with respect and dignity regardless of state of mind or condition;
2. Have privacy and confidentiality related to all aspects of care;
3. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
4. Be part of developing an individual treatment and recovery plan and decision-making regarding his/her treatment and rehabilitative services;
5. Refuse treatment or therapy (unless ordered by a mental health board or court);
6. Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;
7. Be free of any sexual exploitation or harassment;
8. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; and
9. Receive such forms, instructions and assistance as needed to file a complaint or request a state fair hearing.

35-004.07 Billing for Community Support Services: Community Support Services shall be billed in 15-minute increments for a maximum of 144 units per 180 days.
35-004.08 Day Rehabilitation: The Day Rehabilitation program is designed to-

1. Enhance and maintain the client's ability to function in community settings; and
2. Decrease the frequency and duration of hospitalization. Clients served in this program receive rehabilitation and support services to develop and maintain the skills needed to successfully live in the community. Day Rehabilitation is a facility-based program.

35-004.08A Program Components: The program shall provide:

1. Prevocational services including services designed to rehabilitate and develop the general skills and behaviors needed to prepare the client to be employed and/or engage in other related substantial gainful activity. The program does not provide training for a specific job or assistance in obtaining permanent competitive employment positions for clients.
2. Community living skills and daily living skills development.
3. Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms.
4. Planned socialization and skills training and recreation activities focused on identified rehabilitative needs.
5. Skill building in the usage of public transportation and/or assistance in accessing suitable local transportation to and from the Day Rehabilitation program.
6. A scheduled program of services to clients for a minimum of five hours per day, five days per week. Specific services for each client will be individualized, based on client needs.
7. Directly provide or otherwise demonstrate that each client has on-call access to a mental health provider on a (24) hour, (7) days per week basis.

35-004.08B Supportive Services: The program provides the following supportive services for all active clients: referrals, problem identification/solution, and coordination of the Day Rehabilitative program with other services.

35-004.09 Psychiatric Residential Rehabilitation: The Psychiatric Residential Rehabilitation Program is designed to:

1. Increase the client's functioning so that s/he can eventually live successfully in the residential setting of his/her choice, capabilities and resources;
2. Decrease the frequency and duration of hospitalization.

The Psychiatric Residential Rehabilitation program provides skill building in community living skills, daily living skills, medication management, and other related psychiatric rehabilitation services as needed to meet individual client needs. Psychiatric Residential Rehabilitation is a facility-based, non-hospital or non-nursing facility program for persons disabled by severe and persistent mental illness, who are unable to reside in a less restrictive residential setting. These facilities are integrated into the community, and every effort is made for these residences to approximate other homes in their neighborhoods.
35-004.09A Program Components: The program provides -

1. Community living skills and daily living skills development.
2. Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms.
3. Skill building in the usage of public transportation and/or assistance in accessing suitable local transportation to and from the Psychiatric Residential Rehabilitation program.

35-004.09B Licensure Requirements: The program shall be licensed as a Residential Care Facility, Domiciliary, or Mental Health Center by the Department of Health and Human Services.

35-004.09C Staffing Requirements: The program must have the appropriate staff coverage to provide services for clients needing to remain in the residence during the day.

35-004.09D Bed Limitation: The maximum capacity for this facility shall not exceed 16 beds.

35-004.09E Supportive Services: The program provides the following supportive services for all active clients: referrals, problem identification/solution, and coordination of the Residential Rehabilitation program with other services the client may be receiving.

35-005 Referrals for Rehabilitative Psychiatric Services: Referrals for Rehabilitative Psychiatric Services will be directed to the Department or its designee. The referral must include documentation that establishes:

1. The client's Medicaid eligibility; and
2. How the client meets the definition of serious and persistent mental illness specified in 471 NAC 35-001.01.

35-006 Eligibility for Rehabilitative Psychiatric Services: To be eligible for Rehabilitative Psychiatric Services, the client must be eligible for Medicaid, meet the definition of severe and persistent mental illness, and be authorized by the Department or its designee for specific services.

35-007 Service Needs Assessment and Rehabilitative Psychiatric Service Recommendations: All clients determined eligible for rehabilitative psychiatric services must be assessed and have rehabilitative psychiatric service recommendations developed by a referring provider according to specified protocols.
35-008 Service Authorization: The completed assessment and rehabilitative psychiatric service recommendations must be reviewed by the Department or its designee. A determination will be made to -

1. Approve the client for a specified level and duration of one or more rehabilitative psychiatric services;
2. Request additional information from the assessor; or
3. Deny the request for rehabilitative psychiatric services.

35-009 Plan Development: Clients authorized for one or more of the rehabilitative psychiatric services (Community Support, Day Rehabilitation, Residential Rehabilitation) will be referred by the Department or its designee to the appropriate rehabilitative psychiatric services provider(s), consistent with client choice. Rehabilitative psychiatric service providers will be responsible for working with the client to -

1. Complete an assessment of the client's strengths and needs in that service domain according to the requirements of 204 NAC 5 004.05G and 204 NAC 5 004.05H2.
2. Develop, in conjunction with the client, an Individual Service Plan (ISP) for their respective service areas, according to the requirements of 204 NAC 5 004.05I.
3. Participate in developing, along with the client, the client's family members and/or significant others (as appropriate and with client consent), and other relevant community service providers, the client's Individual Program Plan (IPP) according to Department of Health and Human Services specified protocols.

The Community Support program will be assigned responsibility for IPP development and coordination unless otherwise determined by the Department or its designee.

35-010 Utilization Management: The Department or its designee will provide utilization management for all rehabilitative psychiatric services. This will include the service authorization/service intensity functions identified in 471 NAC 35-008. In addition, the Department or its designee will authorize client IPP's and provide ongoing utilization review of the client's progress in relation to the IPP's. At least annually, clients in rehabilitative psychiatric services will be reassessed and new service recommendations will be reviewed and approved by the Department or its designee as described in 471 NAC 35-008.

35-011 Payment for Rehabilitative Psychiatric Services: For services provided on or after April 1, 1995, NMAP pays for rehabilitative psychiatric services at established rates. Rates will not exceed the actual cost of providing rehabilitative psychiatric services.

35-012 Appeals and Fair Hearings: A client has the right to appeal under 465 NAC 2-001.02 and 42 CFR 431, Subpart E. A provider has the right to appeal under 471 NAC 2-003. Hearings are conducted according to 465 NAC 6-000 and 42 CFR 431, Subpart E.

The Department is primarily responsible for the administrative duties of this function.
Assertive Community Treatment: The Assertive Community Treatment (ACT) Team provides high intensity services, available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by client need. The team provides ongoing continuous care for an extended period of time, and clients admitted to the service who demonstrate any continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the client and the team.

Assertive Community Treatment (ACT) is provided by a self-contained clinical team which:

1. Assumes overall responsibility and clinical accountability for clients disabled by severe and persistent mental illness by directly providing treatment, rehabilitation and support services and by coordinating care with other providers;
2. Does not refer clients to outside service providers when services are identified as a responsibility of the ACT program. See 471 NAC 35-013.04C Treatment, Rehabilitation, and Supportive Interventions;
3. Provides services on a long-term basis with continuity of care givers over time;
4. Delivers most of the services outside program offices;
5. Emphasizes outreach, relationship building, and individualization of services;
6. Provides psychiatric treatment and rehabilitation that is culturally sensitive and competent; and
7. Shares team roles expecting each staff member to know all the clients and assist in assessment, treatment planning, and care delivery as needed.

This model of integrated treatment, rehabilitation, and support services is intended to help clients stabilize symptoms, improve level of functioning, and enhance the sense of well being and empowerment. Services provided will focus on treatment and rehabilitation of the effects of serious mental illness, as well as support and assistance in meeting such basic human needs as housing, transportation, education, and employment as necessary for client satisfaction with services and increased quality of life. The goal of the program is to provide assistance to individuals in maximizing their recovery, to ensure client directed goal setting, to assist clients in gaining hope and a sense of empowerment, and provide assistance in helping clients become respected and valued members of their community.

35-013.01 Admission and Discharge Criteria

35-013.01A Admission Criteria: NMAP covers ACT services for those persons disabled by severe and persistent mental illness who are unable to remain stable in community living without high intensity services. ACT services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee. To be eligible for ACT services clients must meet all of the criteria described in 471 NAC 35-001.01, and demonstrate indicators of high need and utilization.
Discharge Criteria: The ACT Program is intended to provide services over a long period of time. Clients admitted to the service who demonstrate continued need for treatment, rehabilitation, or support must not be discharged except by mutual agreement between the client and the ACT Team.

Discharge from the ACT Team occurs when the client and program staff mutually agree to termination of services. Specific documentation must be included in the client's clinical chart when a discharge occurs. Discharge may occur in the following situations:

1. **Geographic Relocation:** The client moves outside the team's geographic area of responsibility. In such cases, the ACT Team must arrange for transfer of mental health service responsibility to a provider wherever the client is moving. To meet this responsibility, the ACT team must maintain contact with the client until this service transfer is arranged.

2. **Significantly Improved Functioning:** The client demonstrates by functional assessment measurement the ability to function in all major role areas (i.e., work, social, self-care) with minimal assistance.

3. **Client Requested Discharge:** Requested discharge despite the team's best efforts to develop an Individual Treatment, Rehabilitation, and Recovery Plan acceptable to the client. Efforts to develop an acceptable Individual Treatment, Rehabilitation, and Recovery Plan must be documented in the client's clinical record.

4. **Hospitalization of the Client in an Institute for Mental Disease (IMD):** The NMAP is not able to reimburse for services provided to clients over age 20 and under age 64 who are being treated in an Institute for Mental Disease.

Staff Requirements: Each ACT Team must provide a comprehensively staffed team, including a psychiatrist, team leader, a peer support person, and program assistants. The ACT Team must have among its staff individuals who are qualified to provide the required services. Each ACT Team must employ, at a minimum, the following number of clinical staff persons, peer support, and psychiatrists to provide the treatment, rehabilitative, and supportive services. Providers are responsible for verifying that staff are appropriately licensed or certified.

Staff Qualifications: All clinical staff must be appropriately licensed or credentialed as required by the Department of Health and Human Services, Division of Public Health. All clinical staff must have at least two years of experience working with persons with serious and persistent mental illness. All clinical staff must maintain sufficient hours of continuing education to maintain certification or licensure.

Background Checks: The employer of the ACT Team members is responsible and accountable for the activities and interventions of the ACT Team staff. The employer must consider which type of criminal background and Abuse/Neglect Central Registry checks are appropriate for their staff and how the results impact hiring decisions. The use of criminal background and Abuse/Neglect Central Registry checks must be described in the employer’s policy and procedure manual and be available for review.
35-013.02C Staff Configuration: The configuration of an ACT Team depends on the number of clients to be served. The ACT Team maintains a 1:10 staff to client ratio (the Team Psychiatrist, and APRN if used, and program assistant are not included in the ratio).

1. Minimum Staff Configuration: The following minimum staffing configuration must be met in each ACT Team regardless of the number of clients served. This configuration may serve up to 50 clients. The team must have at least one member who demonstrates competency in drug/alcohol abuse and dependence or is a licensed alcohol and drug counselor. The clinical staff must include:
   a. Team Psychiatrist: Psychiatric coverage at a minimum ratio of 16 hours per week. This psychiatry time must be spent exclusively on the ACT Team program activities. The minimum services which must be provided by the Team Psychiatrist are:
      (1) The initial in-depth psychiatric assessment and initial determination for medical/pharmacological treatment;
      (2) Individual Treatment, Rehabilitation, and Recovery Plan reviews;
      (3) Weekly clinical supervision; and
      (4) Participation in at least two daily meetings per week.
   b. Advanced Practice Registered Nurse (APRN): An APRN may provide coverage for existing psychiatry time while not replacing the team psychiatrist responsibility in the above services, provided that the APRN:
      (1) Is practicing within his/her scope of practice;
      (2) Has an integrated practice agreement with the team psychiatrist;
      (3) Defines the relationship with the psychiatrist and provides a copy of the integrated practice agreement between the team psychiatrist and the APRN at the time of enrollment, prior to the initiation of services, and at anytime the agreement is modified or terminated.
   c. Team Leader: Each ACT Team must have one full time Team Leader. The Team Leader must have at least a master's degree in nursing, social work, psychiatric rehabilitation, psychology, physician's assistant or is a psychiatrist. The Team Leader must have demonstrated clinical and administrative experience.
   d. Mental Health Professionals: Each team must have one full time Mental Health Professional. A Professional is defined as a person who has completed a Master's or Doctoral degree in a core mental health discipline, and has clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting.
   e. Nursing Staff: Each team must have one full time Registered Nurse.
   f. Mental Health Worker: Each team must have one Mental Health Worker who meets one of the following qualifications:
      (1) Is a licensed Alcohol and Drug Counselor;
      (2) Has a bachelor's degree in rehabilitation or a behavioral health field;
(3) Has a bachelors’ degree in a field other than behavioral sciences or have a high school degree, and has work experience with adults with severe and persistent mental illness or with individuals with similar human services needs; OR

g. **Additional Staff:** Each team must have one additional full time staff person who meets the qualifications of the Mental Health Professional or Mental Health Worker.

h. **Peer Support:** Each team must have a half time coverage of peer support. This team member position must be a self-identified consumer of mental health services. The Peer Support staff must have training, experience, and ability to work with the team in carrying out appropriate aspects of the Individual Treatment, Rehabilitation, and Recovery Plan. The Peer Support staff must have a bachelor’s degree or a high school diploma and either work experience with adults with severe and persistent mental illness, or be able to demonstrate the motivation, learning potential and interpersonal characteristics necessary to benefit from on-the-job training.

i. **Support Staff:** Each ACT Team must have at least one full-time support staff person.

2. **Expanded Staff Configuration:** If an ACT Team will serve more than 50 clients, the following staff must be added:

a. **Registered Nurse:** Teams serving more than 50 clients must have at least one additional Registered Nurse to meet the nursing needs of the expanded population;

b. **Peer Support:** Teams serving more than 50 clients must have full time Peer Support;

c. **Team Psychiatrist:** Teams serving more than 50 clients must maintain additional psychiatric coverage of 2.6 hours for every eight clients; and

d. **Mental Health Professionals:** Teams serving more than 50 clients must have at least two Mental Health Professionals.

3. **Additional Staff:** Teams serving more than 50 clients must maintain a minimum 1:10 staff to client ratio. This ratio excludes the Team Psychiatrist, and APRN if used, and the program assistant. The configuration of the ACT Team must reflect the needs of the client population.

35-013.02D **Staffing Positions:** Each ACT team must have qualified staff assigned to each of the following positions:

1. **Team Leader:** The Team Leader is the clinical and administrative supervisor of the team and has overall responsibility and accountability for assuring that the requirements and functions as stated in these regulations are met. The Team Leader also functions as a practicing clinician on the ACT Team. The Team Leader ensures that all clinical tasks are completed or rescheduled and manages team response to all emergencies or crisis situations in consultation with the Team Psychiatrist. This is a full time position.
2. **Team Psychiatrist:** The Team Psychiatrist functions must be provided by a psychiatrist who is Board-certified or Board-eligible on a full-time or part-time basis. The Team Psychiatrist position may be shared by more than one psychiatrist and/or an APRN (see 471 NAC 35-013.02C(a and b)). The Team Psychiatrist provides clinical services including psychiatric assessment, Individual Treatment, Rehabilitation, and Recovery Plan development and approval, psychopharmacologic and medical treatment, and crisis intervention to all ACT Team clients. The Team Psychiatrist is available 24 hours per day and seven days per week for crisis management. The Team Psychiatrist works with the Team Leader to monitor each client’s clinical status and response to treatment, provides staff clinical supervision, and participates in the development of all Individual Treatment, Rehabilitation, and Recovery Plans. The rate of reimbursement for ACT programs that provide psychiatric coverage with less than 16 hours of a psychiatrist’s time (psychiatrist and APRN combination) will be adjusted accordingly. (Please see the fee schedule for procedure code and rate).

3. **Advanced Practice Registered Nurse:** If an ACT Team includes an APRN to provide services included as part of the required team psychiatrist hours, the APRN must work collaboratively with the psychiatrist. An APRN is able to provide services, except for the mandatory services which must be delivered by the team psychiatrist as described in 471 NAC 35-013.02C(1a.). The Team Psychiatrist must be available for consultation and direction of the treatment activities provided by an APRN, within his/her scope of practice. Psychiatric 24/7 coverage must be documented via a written agreement between the psychiatrist and the APRN. A copy of the agreement must be sent to Medicaid at the time of enrollment.

4. **Peer Support:** The Peer Support staff performs clinical work based on their credentials and abilities.

5. **Team Member:** Team Members carry out treatment, rehabilitation, and support interventions consistent with their training and scope of licensure.

6. **Program Assistant:** The program assistant is a non-clinician responsible for working under the direction of the Team Leader to support all non-clinical operations of the ACT Team. This is a full time position and not considered in the staff to client ratio.

35-013.02E **Staff Functions:** The ACT Team must perform the following functions:

1. **Clinical Supervision:** Clinical Supervision is regular contact between a designated senior clinical supervisor and a member of the ACT Team to:
   a. Review the client’s clinical status,
   b. Ensure appropriate treatment services are provided to the client, and
   c. Review and improve the ACT Team member’s service provision.
   Clinical Supervision may occur during Daily Team Meetings, Individual Treatment, Rehabilitation, and Recovery Plan Meetings, side-by-side and face-to-face supervision sessions, and through a review of the client’s clinical record and in other appropriate activities. Clinical Supervision must be appropriately documented. The Team Leader and/or the psychiatrist is responsible for supervising and directing all ACT Team activities.

2. **Crisis Intervention and Response:** In addition to the client specific Crisis Intervention plans, the ACT Team must have a procedure to respond to
3. emergencies and crises. This includes, but is not limited to, 24-hour crisis intervention availability.

Assessment: Initial and updated assessments of the client must be provided as described in 471 NAC 35-013.04A. Appropriate staff must be assigned to this function based on individualized client need. The client and his/her family (as allowed by client permission) must be involved in all assessments.

4. Treatment Planning: Initial and updated Individual Treatment, Rehabilitation, and Recovery Plans must be developed as described in 471 NAC 35-013.04B. In addition to the Team Leader and Team Psychiatrist, appropriate staff must be assigned to this function based on individualized client need. One specific staff person must be designated to document the Individual Treatment, Rehabilitation, and Recovery Plan for the clinical record. The client and his/her family (as allowed by client permission) must be involved in development, review, and revision of all Individual Treatment, Rehabilitation, and Recovery Plans.

5. Individual Treatment, Rehabilitation, and Recovery Plan Coordination: Individual Treatment, Rehabilitation, and Recovery Plan Coordination is an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to a client in a planned, coordinated, efficient and effective manner, as outlined in the Individual Treatment, Rehabilitation, and Recovery Plan.

6. Interventions: Based on individualized client need and preference and ACT Team qualifications, experience, and training, ACT Team members must be assigned to provide the active treatment, rehabilitative, and supportive services described in 471 NAC 35-013.04C.

35-013.03 ACT Program Organization

35-013.03A Hours of Operation, Coverage, and Availability of Services: The ACT Team must meet the following regulations related to availability and scheduling.

1. Hours of Operation and Availability of Services: The ACT Team must be available to provide treatment, rehabilitation, and support interventions 24 hours per day, seven days per week, 365 days a year. The ACT Team must be able to:
   a. Meet the clients’ needs at all hours of the day including evenings, weekends, and holidays;
   b. Provide services at the time that is most appropriate and natural for the client as described in the client’s Individual Treatment, Rehabilitation, and Recovery Plan; and
   c. Operate a minimum of 12 hours per day and eight hours each weekend day and every holiday.

2. Psychiatric Coverage: Psychiatric coverage must be available at all times. If availability of the Team Psychiatrist during all hours is not feasible, alternative psychiatric backup (including the APRN) must be arranged.
The covering psychiatrist or APRN must have an orientation to the ACT Team concept and be supportive of its services. The covering psychiatrist or APRN must be able to get client specific information from an ACT Team member.

35-013.03B Service Intensity: The ACT Team services must be able to provide the level of service intensity as dictated by client need. Client need is determined through the severity of symptoms and problems in daily living and is documented in the client’s Individual Treatment, Rehabilitation, and Recovery Plan. No other psychiatric service or psychiatric rehabilitation service may be reimbursed, except for acute and subacute inpatient hospitalization for assessment and stabilization, when prior authorized by Medicaid and Long-Term Care or its designee.

35-013.03C Place of Service: The ACT Team must provide most of the interventions and service contacts in the community, in non-office based settings.

35-013.03D Shared Responsibility: The responsibility of the total client caseload is shared by the entire ACT Team, even though team members may serve as a primary contact for certain clients. Over time, every team member gets to know every client and every client gets to know every team member.

35-013.03E Staff Communication and Planning: The ACT Team must use systems and methods for continuous daily communication and planning. These must include:

1. **Daily Organizational Staff Meeting:** A Daily Organizational Staff Meeting must be held to review the status of all program clients, update the Team on contacts provided in the past 24 hours and to communicate essential information on current events and activities as they relate to the interventions provided by the ACT Team.

2. **Daily Team Assignment Schedule:** The Daily Team Assignment Schedule must list all of the interventions that need to be provided on that day and the ACT Team member assigned to complete the intervention.

3. **Daily Log:** The Daily Log must be used to document that a client review has occurred.

4. **Client Weekly Contact Schedule:** The Client Weekly Contact Schedule must be a written schedule of all treatment, rehabilitation, and support interventions which staff must carry out to fulfill the goals and objectives in the client’s Individual Treatment, Rehabilitation, and Recovery Plan.

5. **Individual Treatment, Rehabilitation, and Recovery Plan Meetings:** Individual Treatment, Rehabilitation, and Recovery Plan Meetings must be regularly scheduled meetings to identify and assess individual client needs/problems; to establish measurable long and short term treatment and service goals; to plan treatment and service interventions; and to assign staff persons responsible for providing the services if the client and their family are not able to participate, the meeting must include their input. Appropriate support must be provided to maximize the participation of the client and their family. If necessary, the Individual Treatment, Rehabilitation and Recovery Plan should address any barriers to
participation. The ACT Team must conduct Individual Treatment, Rehabilitation, and Recovery Plan Meetings, under the supervision of the Team Leader and Team Psychiatrist.

35-013.04 Program Components and Interventions: Operating as a continuous treatment and rehabilitative service, the ACT Team must have the capability to provide assessment, comprehensive treatment, rehabilitation, and support services as a self-contained clinical service unit. Services must be available 24 hours a day, seven days a week, 365 days per year. Services must be provided by the most appropriate ACT Team members operating within their scope of practice. Services must include, but are not limited to:

**35-013.04A Assessment and Evaluation**

35-013.04A1 Initial Admission Assessment: Prior to accepting the client for admission, the ACT Team must assess and determine the appropriateness of the client for admission to the ACT Team program. The assessment must include a review of clinical information and client interview and may include additional assessment activities.

35-013.04A2 Comprehensive Assessment: The Comprehensive Assessment is unique to the ACT Program in its scope and completeness. A Comprehensive Assessment is the process used to evaluate a client's past history and current condition in order to identify strengths and problems, outline goals, and create a comprehensive Individual Treatment, Rehabilitation, and Recovery Plan. The Comprehensive Assessment reviews information from all available resources including past medical records, client self-report, interviews with family or significant others if approved by the client, and other appropriate resources, as well as current assessment by team clinicians from all disciplines. A Comprehensive Assessment must be initiated and completed within 30 days after the client's admission to the ACT program, according to the following requirements:

1. Each assessment area must be completed by staff with skill and knowledge in the area being assessed and must be based upon all available information, including client self-reports, reports of family members and other significant parties, written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, interviews with the client, and standardized assessment materials.
2. The Comprehensive Assessment must include a thorough medical and psychiatric evaluation and must identify client strengths as well as problems. The assessment must gather sufficient information to develop an Individual Treatment, Rehabilitation, and Recovery Plan.
3. The Comprehensive Assessment may be revised during a client’s tenure in the ACT Program. Information may be added, revised, or clarified.

**35-013.04B Individual Treatment, Rehabilitation, and Recovery Plan Development and Coordination:** Individual Treatment, Rehabilitation, and Recovery Plan Development
and Coordination is a continuing process involving each client, the client's family, guardian, and/or support system as appropriate, and the team which individualizes service activity and intensity to meet client-specific treatment, rehabilitation and support needs. The written Individual Treatment, Rehabilitation, and Recovery Plan documents the client's goals and the services the client will receive in order to achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.

An Initial Individual Treatment, Rehabilitation, and Recovery Plan must be developed upon the client's admission to the ACT Team.

The Comprehensive Individual Treatment, Rehabilitation, and Recovery Plan must be developed for each client within 21 days of the completion of the Comprehensive Assessment. This Individual Treatment, Rehabilitation, and Recovery Plan will be developed and revised according to the following regulations:

35-013.04B1 Comprehensive Individual Treatment, Rehabilitation, and Recovery Plan Development: A comprehensive Individual Treatment, Rehabilitation, and Recovery Plan is developed through an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to the client in a planned, coordinated, efficient and effective manner. The Comprehensive Individual Treatment, Rehabilitation, and Recovery Plan provides a systematic approach for meeting a client's needs, treatment rehabilitation, and support needs, and documenting progress on treatment, rehabilitation, and service goals.

The following key areas must be addressed in the Individual Treatment, Rehabilitation, and Recovery Plan based upon the individual needs of the client: symptom stability, symptom management and education, housing, activities of daily living, employment and daily structure, family and social relationships, and crisis support.

This plan must:

1. Identify the client's needs and problems;
2. List specific long and short term goals with specific measurable objectives for these needs and problems;
3. List the specific treatment and rehabilitative interventions and activities necessary for the client to meet these objectives and to improve his/her capacity to function in the community; and
4. Identify the ACT Team members who will be providing the intervention.

The Individual Treatment, Rehabilitation, and Recovery Plan must be developed in collaboration with the client and/or guardian, if any, and, when appropriate, the client's family.
The client's participation in the development of the Individual Treatment, Rehabilitation, and Recovery Plan must be documented. The plan must be signed by the client and the Team Psychiatrist.

35-013.04B2 Individual Treatment, Rehabilitation, and Recovery Plan Reviews: The ACT Team must review and revise the client's Individual Treatment, Rehabilitation, and Recovery Plan every six months, whenever there is a major decision point in the client's course of treatment, or more often if necessary. The Team Psychiatrist, Team Leader, and appropriate staff from the ACT Team must participate in each Individual Treatment, Rehabilitation, and Recovery Plan Review. The ACT Team must include the client in the review. Guardians and/or family members should be encouraged to participate, as allowed by the client.

The Individual Treatment, Rehabilitation, and Recovery Plan Review must be documented in the client's clinical record. This documentation must include a description of the client's progress and functioning since the last Individual Treatment, Rehabilitation, and Recovery Plan Review, the client's current functional strengths and limitations, a list of attendees, the discussion related to the Individual Treatment, Rehabilitation, and Recovery Plan, and any changes to the plan. The plan and review will be signed by the client and the Team Psychiatrist.

The signature of the Team Psychiatrist indicates this is the most appropriate level of care for the client and that the treatment, rehabilitative, and service interventions are medically necessary.

35-013.04B3 Client and Family Participation: The ACT Team is responsible for engaging the client in active involvement in the development of the treatment/service goals. With the permission of the client, ACT Team staff must involve pertinent agencies and members of the client's family and social network in the formulation of Individual Treatment, Rehabilitation, and Recovery Plans.

35-013.04C Treatment, Rehabilitative, and Supportive Interventions: The ACT Team must be able to provide treatment, rehabilitative, and supportive interventions to clients assigned to the ACT Team. The interventions are categorized into three areas and the specific application of each type of intervention must be based on the client's specific goals and objectives. The interventions must address the needs identified in the Comprehensive Assessment. While there are no requirements that the client receive a minimum number of a specific categories of intervention, the client must receive the interventions that are appropriate for their needs.

All interventions must be performed by professionals acting within the appropriate scope of practice.

35-013.04C1 Treatment Interventions:

1. Medical Assessment, Management, and Intervention: The ACT Team must provide the interventions necessary to treat the client's psychiatric and physical conditions.
2. Individual, Family, and Group Therapy or Counseling: The ACT Team must provide individual, family, and group therapy or counseling to assist the client to gain skills in interpersonal relationships, identify and resolve conflicts, and systematically work on identified individual goals. These interventions focus on lessening distress and symptomology, improving psychological defenses and role functioning, and increasing and reinforcing the client's understanding of and participation in treatment, rehabilitative services, and activities of daily living.

3. Medication: The ACT Team must provide the prescription, preparation, delivery, administration, and monitoring, of medications.

4. Crisis Intervention: The ACT Team must provide Crisis Intervention Services by assessing client needs that require immediate attention and initiate a resolution to the need.

5. Substance Abuse Services: The ACT Team must provide Substance Abuse Services to assist the client in achieving periods of abstinence and stability. The interventions include, but are not limited to assessment, individual and group counseling, education, and skill development. The interventions should help the client:
   a. Learn to identify substance use, effects, and patterns,
   b. Recognize the relationship between substance use, mental illness and psychotropic medications, and
   c. Develop motivation to eliminate or decrease substance use and coping skills or alternatives to minimize substance use.

35-013.04C2 Rehabilitative Interventions:

1. Symptom Management Skill Development: The ACT Team must provide Symptom Management Skill Development to help the client cope with and gain mastery over symptoms and functional impairments in the context of adult role functioning.

2. Vocational Skill Development: The ACT Team must provide Vocational Skill Development that includes individualized assessment and planning for employment based upon functional assessment and the client's needs, desires, interests and abilities.

3. Activities of Daily Living and Community Living Skill Development: The ACT Team must provide services to help the client rehabilitate their functional impairments and limitations related to activities of daily living and living in a community setting. The services will help clients carry out personal hygiene and grooming tasks, perform household activities, find housing which is safe and affordable, develop or improve money management skills, use available transportation, and have and effectively use a personal physician and dentist.

4. Social and Interpersonal Skill Development: The ACT Team must provide interventions to help the client rehabilitate their social functioning. The goals include, but are not limited to improved communication skills, developing assertiveness, developing social
skills and meaningful personal relationships, appropriate and productive use of leisure time, relating to others effectively, familiarity with available social and recreational opportunities and support groups, and increased use of such opportunities.

5. **Leisure Time Skill Development** The ACT Team must provide interventions to rehabilitate the client’s ability to use leisure time appropriately.

35-013.04C3 **Supportive Interventions:**

1. **Assistance:** The ACT Team must provide support services, direct assistance, and coordination to ensure that the client obtains the basic necessities of daily life. These necessities include, but are not limited to: medical and dental services, safe, clean, affordable housing, financial support, social services, transportation, legal advocacy and representation, education, employment, food, and clothing.

2. **Support:** The ACT Team must provide support to clients, on a planned and "as needed" basis, to help them accomplish their personal goals, gain a sense of personal mastery and empowerment, and to cope with the stresses of day-to-day living. This includes interaction that focuses on decreasing distress, improving understanding and reinforcing the client’s participation in services.

3. **Family Involvement:** The ACT Team will provide education, support and consultation to clients' families and other major supports, with client agreement and consent. The ACT Team must encourage family members and other major sources of support to be involved in the services received by the client unless prohibited by the client, through legal action, or because of confidentiality laws. This includes education about the client's illness and condition and the role of the family in the therapeutic process, intervention to resolve conflict, and ongoing communication and collaboration between the ACT Team and the client’s family.

4. **Positive Peer Role Modeling:** The ACT Team will offer opportunities for positive peer role modeling and peer support including practical problem solving approaches to daily challenges, peer perspective on steps to recovery and support, mentoring toward greater independence, empowerment, and ability to manage severe symptomology.

35-013.05 **National Accreditation and Certification:** Providers must be nationally accredited under specific ACT Team standards, such as CARF (Commission on Accreditation of Rehabilitation Facilities), or must be actively pursuing accreditation in order to be enrolled. Providers that are actively pursuing accreditation with a national body must submit their accreditation plan for consideration. Providers actively pursuing accreditation will be enrolled on a provisional status.
35-013.06 Clinical Documentation Requirements: Records must be kept in accordance with the national accreditation body surveying the provider. The clinical records for ACT Team services must include the following information:

1. Client identifying and demographic information;
2. Assessments and Evaluations;
3. Team Psychiatrist's orders;
4. Treatment, Rehabilitation and Service Planning;
5. Current Medications;
6. Progress and contact notes must be recorded by all ACT Team members providing services to the client;
7. Reports of consultations, laboratory results, and other relevant clinical and medical information;
8. Documentation of the involvement of family and other significant others; and
9. Documentation of transition and discharge planning.

35-013.06A Discharge Documentation: Documentation of discharge from the ACT program must include.

35-013.07 Performance Improvement and Program Evaluation: The ACT Team must have a performance improvement and program evaluation plan which meets the criteria for accreditation in the approved national accreditation organization. In addition, the program will participate in all aspects of statewide ACT evaluation projects.

35-013.08 Provider Enrollment: An ACT Team must complete Form MC-19, “Medical Assistance Provider Agreement,” and submit the completed form and a program overview that addresses the requirements in these regulations to the Division of Medicaid and Long-Term Care for approval. The ACT Team must maintain written policies and procedures that document compliance with all of the standards and requirements in 471 NAC 35-002. The provider will be advised in writing when its participation is approved. Annual updates of enrollment may be required. The provider must submit updates of the identity and expertise of ACT Team members as new staff are added to the program.

35-013.09 Program Review: The ACT Team will be reviewed regularly by the Division of Medicaid and Long-Term Care or its designee.

35-013.10 Prior Authorization: Reimbursement for services from the ACT Team must be authorized by the Division of Medicaid and Long-Term Care or its designee.

35-013.11 Telehealth: ACT Team interventions may be provided via telehealth when provided according to the regulations 471 NAC 1-006.

35-013.12 Reimbursement and Billing Information: NMAP pays for assertive community treatment services at established rates. Providers must follow these billing requirements:

1. Claims for services provided by the ACT Team must be billed on an appropriately completed Form CMS-1500 or the standard electronic health claim form Professional transition ASC X 12N 837 (see claim submission table 471-000-49);
2. Claims for ACT Team services must use the procedure codes determined by the Department; and
3. The unit of service for ACT Team reimbursement is one day.

35-013.13 Hospital Admissions: In the event that a client requires hospitalization while receiving services from the ACT Team, NMAP will continue to reimburse the ACT Team services for up to 15 days per hospitalization. The ACT Team must maintain as much involvement with the client as possible, based on client preference and authorization to release information. This includes providing interventions to the client, participating in transition and discharge planning, and any other appropriate involvement.

35-013.14 Limitations on the Reimbursement for ACT Team Services: The following situation limits NMAP reimbursement for ACT Team Services. Because regulations prohibit federal financial participation in the reimbursement of services to clients age 21 to 64 in an IMD (Institute for Mental Disease), Medicaid eligibility for clients who are admitted to an IMD for longer than 10 days will be closed.
Secure Psychiatric Residential Rehabilitation: Secure Psychiatric Residential Rehabilitation is a secure facility-based, non-hospital or non-nursing facility program for individuals disabled by severe and persistent mental illness, who are unable to reside in a less restrictive setting. These facilities are integrated into the community and provide programming in an organized, structured setting, including treatment and rehabilitation services and offer support to clients with a severe and persistent mental illness and/or co-occurring substance abuse disorders. These individuals demonstrate a moderate to high risk for harm to self/others and are in need of recovery, treatment, and rehabilitation services. The clients who are in need of this level of care have long standing limitations with limited ability to live independently over an extended period of time. These individuals have needed a high level of psychiatric intervention and have limitations in all three functional areas, vocational/educational, social skills and activities of daily living. See definitions in 471 NAC 35-001.01. The Secure Psychiatric Residential Rehabilitation program provides skill building and other related recovery oriented psychiatric rehabilitation services as needed to meet individual client needs. The Secure Psychiatric Residential Rehabilitation Program is designed to:

1. Increase the client's functioning while improving psychiatric stability so that s/he can eventually live successfully and safely in a less restrictive residential setting of his/her choice and capabilities;
2. Decrease the frequency and duration of hospitalization;
3. Decrease and/or eliminate all high risk, unsafe behavior to self or others; and
4. Improve the ability to function independently by improving ability to function.

Program Components: A secure psychiatric residential rehabilitation program provides a variety of on-site psychosocial rehabilitation and skill acquisition activities and treatment each day. The program must facilitate client driven skills training and activities as appropriate. A secure psychiatric residential rehabilitation program must provide services identified on the client specific Individual Treatment, Rehabilitation, and Recovery Plan, providing culturally-sensitive and trauma-informed care. The activities must include, but are not limited to:

1. Ongoing assessment;
2. Arrangement for general medical care including laboratory services, psychopharmacological services, psychological services, as necessary;
3. Provision of a minimum of 42 hours per week of on-site staff led psychosocial rehabilitation activities and skill acquisition;
4. Programming focused on relapse prevention, recovery, nutrition, daily living skills, social skill building, community living, substance abuse, education, medication education and self-administration, symptom management, and focus on improving the level of functioning to get to a less restrictive level of care;
5. Educational and vocational focus as appropriate; and
6. Access to community-based rehabilitation/social services to assist in transition to community as symptoms are managed and behaviors are stabilized.
35-014.01A Assessments: The following assessments must be completed:

1. A comprehensive mental health and substance use disorder assessment by an independently licensed mental health practitioner must occur prior to admission.
2. Following admission and within 24 hours of stay, an assessment by the program's psychiatrist must be completed.
3. A history and physical must be completed by a physician or Advanced Practice Registered Nurse (APRN) within 24 hours of admission or one must be completed within 60 days of admission and available in the clinical record.
4. A nursing assessment must be completed by a Registered Nurse within 24 hours of admission.
5. A functional assessment must be completed initially upon admission and annually with continued stay at this level of service.
35-014.01B Individual Treatment, Rehabilitation, and Recovery Planning: An initial Individual Treatment, Rehabilitation, and Recovery Plan must be completed within 24 hours of admission. Secure Psychiatric Residential Rehabilitation Service providers must develop an individual treatment, rehabilitation, and recovery plan with the client within 30 days following admission to the program. The plan must include substance abuse issues. The client’s family and/or guardian must be included in all assessment and treatment, rehabilitation, and recovery planning. The provider must make every effort to be available and responsive to the client’s family and/or guardian to assist their involvement in the client’s recovery. The plan must be reviewed and revised with the client, discussing and documenting the discharge plan a minimum of every 7 days according to the following requirements.

35-014.01B1 Individual Treatment, Rehabilitation, and Recovery Plan: The master individual treatment, rehabilitation, and recovery plan must be based upon a comprehensive assessment and completed within 30 days of admission. This plan must:

1. Be oriented to the principles of recovery and meaningful client participation;
2. Apply the principles of recovery – to include meaningful client participation, and a life in the community of the client’s choosing;
3. Incorporate and be consistent with best practices;
4. Include the client’s individualized goals and expected outcomes;
5. Contain prioritized objectives that are measurable and time-limited;
6. Describe therapeutic interventions to be used in achieving the goals and objectives that are recovery-oriented, trauma-informed, and strength-based;
7. Identify staff responsible for implementing the therapeutic interventions;
8. Specify the planned frequency and duration of each therapeutic method;
9. Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care and reviewed weekly;
10. Include a plan developed with the client that includes strategies to avoid crisis or admission to a higher level of care using principles of recovery and wellness;
11. Include the signature of the client and/or parent/guardian;
12. Include health care proxy and trauma safety form when available and with client’s consent;
13. Document that the individual treatment, rehabilitation, and recovery plan is completed within the timeframe specified in the program's policies and procedures;
14. Document that the plan has been reviewed, updated every 30 days, and revised according to client needs and progress; and
15. Document that the plan was reviewed by the program's treatment practitioners a minimum of every 30 days and that written revisions were approved, signed, and dated each 30 days by the program psychiatrist.

35-014.01C Treatment Services: The program must offer structured, planned treatment and rehabilitation services as prescribed by the individualized treatment, rehabilitation, and recovery plan. The following services must be available and offered to the client.

1. Individual Psychotherapy: An individual treatment and rehabilitation service between an identified client and a qualified licensed practitioner who focuses upon the identified goals of the individual treatment, rehabilitation, and recovery plan;
2. Group Psychotherapy: A service provided by a licensed clinician who is practicing within his/her scope of practice and provides a psychotherapy service in groups of no less than three and no more than twelve clients;
3. Family Therapy: Family therapy is a therapeutic service between the client and his/her family and a qualified licensed practitioner who provides intervention as identified by the family-focused goals of the individual treatment, rehabilitation, and recovery plan. Consent from the client must be documented prior to the involvement of the family and delivery of the service; and
4. Psychoeducational services, such as medical education by a registered nurse and skill development groups by a trained and skilled staff able to facilitate these groups supervised by a licensed mental health practitioner.

35-014.01D Supportive Services: The program must provide the following supportive services for all active clients: referrals as necessary, problem identification/solution, and coordination of the Secure Psychiatric Residential Rehabilitation program treatment and activities with other services the client may be receiving.

35-014.02 Staffing: The Secure Psychiatric Residential Rehabilitation provider must contract with or employ a licensed psychiatrist for the program. The psychiatrist's hours must be at a sufficient level to provide weekly direct contact with the client; to provide assessment; to review the individual treatment, rehabilitation, and recovery plan; to evaluate client's level of progress; to assist in eliminating barriers to recovery; and to provide psychiatric consultation as necessary on a 24/7 basis. Programs must have staff available in skill and numbers to meet the acuity of the clients being served. Programs must have ability to call staff back when necessary.

35-014.02A Staffing Standards: Secure Psychiatric Residential Rehabilitation providers must meet the following minimum staffing requirements. The program must employ a:

1. Program Director;
2. Licensed Mental Health Practitioner (LMHP) or a Licensed Mental Health Practitioner/Licensed Alcohol and Drug Counselor (LMHP/LADC). A dual Licensed Practitioner is preferred;
3. Registered nurse;
4. Direct care staff.

35-014.02A1 The Program Director must:

1. Be fully licensed as a Mental Health Practitioner (APRN, RN, LMHP, LIMHP or psychologist); and
2. Possess leadership, supervisory, and management skills.

35-014.02A1a Responsibilities of the Secure Psychiatric Residential Rehabilitation Program Director: The program director must:

1. Complete and sign a comprehensive Biopsychosocial Assessment for each client within 14 days of admission or delegate responsibility for the assessment to the program's licensed practitioner who functions as the therapist for the program;
2. Develop, approve, and sign an initial individual treatment, rehabilitation, and recovery plan within the first 24 hours of admission;
3. Supervise and participate in the development of a comprehensive individual treatment, rehabilitation, and recovery plan with the client and the program staff within 30 days of admission. The program director must approve and sign the plan prior to implementation;
4. Supervise the professional staff and direct care staff by on site presence during programming;
5. Assure adequate staff training through initial and ongoing training sessions and provide supervision of staff competency checks;
6. Supervise and provide direction regarding all documentation requirements, including organization and completeness of clinical records; and
7. Supervise and direct the development and implementation of the discharge plan.

35-014.02A2 Responsibilities of the Registered Nurse: The registered nurse must:

1. Complete a nursing assessment within 24 hours of admission;
2. Participate in the development of the individual treatment, rehabilitation, and recovery plan and the plan updates;
3. Oversee and monitor daily medication administration;
4. Provide medication education as necessary;
5. Communicate with the psychiatrist and physician consultants as necessary;
6. Monitor, supervise, and oversee the program’s daily activities in conjunction with and in the absence of the Program Director.
35-014.02A3 Responsibilities of the Mental Health Practitioner: The mental health practitioner must:

1. Complete a comprehensive assessment within 14 days of admission when this responsibility is delegated by the program director;
2. Participate in the development of the individual treatment, rehabilitation, and recovery plan and the updates;
3. Provide individual, group and family psychotherapy according to the client's individual treatment, rehabilitation, and recovery plan;
4. Communicate with the Program Director and psychiatrist regarding the clinical needs of the client as necessary;
5. Monitor, supervise, and oversee the program's daily treatment and activities in the absence of the Program Director as assigned by the Program Director;
6. Assist with aggressive discharge planning; and
7. Maintain a maximum staffing ratio of 1 to 8 clients.

35-014.02A4 Direct Care Staff: The Secure Psychiatric Residential Rehabilitation Program must employ direct care staff who:

1. Are on site and available to the clients at a ratio of one staff per four clients during awake hours and a minimum of one awake direct care per staff per six clients during overnight hours;
2. Staff to client ratios must be enhanced to meet client need as necessary.
3. Direct Care staff having a bachelor's degree in psychology, sociology or related human services field but two years of course work in the human services field and two years of experience/training or two years of lived recovery experience is acceptable. Each staff must have demonstrated skills and competency in treatment with individuals with mental health diagnosis.

35-014.03 Discharge Planning: Throughout a client's care and whenever the client is transitioned from one level of care to another, discharge planning must occur in advance of this discharge. It must include the client's and client's family/legal guardian's input and be documented in the client's clinical record. The plan must be recovery-oriented, trauma-informed, and strength-based.

Providers must meet the following standards regarding recovery and discharge planning:

1. Discharge planning must begin on admission to the service with input and participation of the client and client's family/guardian;
2. Discharge planning must include the client and family input and be consistent with the goals and objectives identified in the individual treatment, rehabilitation, and recovery plan and clearly documented in the clinical record;
3. Discharge planning must address the client's needs for ongoing services to maintain the gains and to continue as normal functioning as possible following discharge. A crisis/relapse/safety plan must be in place;
4. Providers must make or facilitate referrals and applications to the next level of care and/or community support services, such as use of medications, housing, employment, transportation, and social connections;

5. Providers must arrange for the prompt transfer of clinical records and information to ensure continuity of care; and

6. A written discharge summary must be provided as part of the clinical record. It must identify the readiness for discharge and contain the signature of a fully licensed clinician and date of signature and must identify a summary of the services provided.

35-014.04 Clinical Documentation: Secure Psychiatric Residential Rehabilitation service providers must maintain a clinical record that is confidential, complete, accurate, and that contains up-to-date information relevant to the client’s care and services. The record must sufficiently document comprehensive assessments; individual treatment, rehabilitation, and recovery plans; and plan reviews. The clinical record must document client contacts describing the nature and extent of the services provided, so that a clinician unfamiliar with the service is able to identify the client’s service needs and services received. The documentation must reflect the rehabilitative services provided; that the care is consistent with the goals in the individual treatment, rehabilitation, and recovery plan; and that the care is based upon the comprehensive assessment. The absence of appropriate, legible, complete records may result in the recoupment of previous payments for services. Each entry must identify the date, beginning and ending time spent providing the service and location of service, and identify by name and title the staff person entering the information.

Clinical records must be maintained at the client’s primary rehabilitation site. Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of rehabilitation information is subject to all the provisions of applicable State and Federal laws. The client’s clinical record must be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

35-014.05 The clinical record must include, at a minimum:

1. Client identifying data, including demographic information and the client’s legal status;
2. Assessment and Evaluations:
   a. Psychiatric assessment, including the name of the clinician and the date of the assessment;
   b. Comprehensive Assessment; and
   c. Other related assessments;
3. The client’s diagnostic formulation (including all five axes);
4. The Individual Treatment, Rehabilitation, and Recovery Plan and updates to plans;
5. Documentation of review of client rights with the client;
6. A chronological record of all services provided to the client. Each entry must include the date the intervention was performed, the duration of the intervention (beginning and ending time), the place of the service, and the staff member’s identity and legible signature (name and title);
7. Documentation of the involvement of family and significant others;
8. Documentation of treatment and recovery services and discharge planning;
9. A chronological listing of the medications prescribed (including dosages and schedule) for the client and the client's response to the medication;
10. Documentation of coordination with other services and treatment providers;
11. Discharge summaries from previous levels of care;
12. Discharge summary (when appropriate); and
13. Any clinical documentation requirements identified in the specific service.

35-014.06 Clients' Rights: Individual staff and the treatment, rehabilitation, and recovery team must provide interventions in a manner that support and maintain the client's rights with a continuous focus on client empowerment and movement toward recovery. Secure Psychiatric Residential Rehabilitation programs must have written a client rights and responsibility policy. Staff must review client rights, responsibilities, and grievance procedures with each new client at admission and on an ongoing manner, and must document this review in the clinical record. Secure Psychiatric Residential Rehabilitation programs must comply with all state and federal clients' rights requirements.

The following rights apply to clients receiving secure psychiatric residential rehabilitation services through Medicaid. The client has the right to:

1. Be treated with respect and dignity regardless of state of mind or condition;
2. Have privacy and confidentiality related to all aspects of care;
3. Be protected from neglect; physical, emotional, or verbal abuse and exploitation of any kind;
4. Be part of developing an individual treatment, rehabilitation, and recovery plan and decision-making regarding his/her mental health treatment and rehabilitative services;
5. Refuse treatment or therapy (unless ordered by a mental health board or court);
6. Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;
7. Be free of any sexual exploitation or harassment; and
8. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner.

35-014.07 Provider Participation: To participate in Medicaid as a provider of secure psychiatric residential rehabilitation services, a program must be enrolled as a Nebraska Medical Assistance Program provider according to the Medicaid regulations. Providers must complete the credentialing into the Medicaid Managed Care network prior to providing services to Medicaid Managed Care beneficiaries. The provider must complete and sign Form MC-19, “Medical Assistance Provider Agreement,” and be approved for enrollment in Medicaid. In addition, eligible providers must also provide documentation as requested. Providers must notify Medicaid and/or its designee of any substantive changes in the program or staff providing services. Providers are required to provide annual updates of program information and cost information to determine ongoing compliance with Medicaid regulations. Providers must maintain documentation of policies and procedures that meet the standards and regulations described in this chapter.
35-014.08 Licensure and Accreditation Requirements: The program must be licensed as a Mental Health Center by the Department of Health and Human Services, Division of Public Health, and it must be accredited by a national accrediting agency such as Commission on Accreditation of Health Care Organization (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA). Providers must have maintained their licensure and accreditation as a condition for continued participation in Medicaid.

35-014.09 Bed Limitation: The maximum capacity for the provider of secure psychiatric residential rehabilitation services must not exceed 16 beds. There must be no waiver of this regulation over the 16-bed limitation.

35-014.10 Treatment Prior Authorization: All Secure Psychiatric Residential Rehabilitation Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee. These reviews include prior authorization and continued stay reviews. Referrals for Secure Psychiatric Residential Rehabilitation Services must be directed to the Division of Medicaid and Long-Term Care or its designee and must follow established protocols for prior authorization and utilization management.

35-014.11 Therapeutic Pass Days: Therapeutic passes are an essential part of the rehabilitation process for clients involved in secure psychiatric residential rehabilitation services. Documentation of the client’s continued need for secure psychiatric residential rehabilitation services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the individual treatment, rehabilitation, and recovery plan as therapeutic passes become appropriate. Medicaid reimburses for 21 therapeutic pass days per client per calendar year when the client is on therapeutic leave for purposes of testing ability to function and transition to lesser level of care.

35-014.12 Hospitalizations: In the event that a client does require hospitalization while in a secure psychiatric residential rehabilitation program, Medicaid will reimburse the Secure Psychiatric Residential Rehabilitation Program for up to ten days per hospitalization. This reimbursement is only available if the bed is not used by another client and the client returns to the bed occupied prior to hospitalization.

35-014.13 Inspections of Care (IOC): The Division of Medicaid and Long-Term Care or its designee may periodically inspect the care which includes the treatment, rehabilitative, and recovery services provided to clients in each type of service. The Inspection of Care team will include staff who are knowledgeable about mental health and rehabilitative psychiatric services and may include clients and/or Division of Medicaid and Long-Term Care consultants.

The purpose of the Inspection of Care is to assess compliance with Medicaid regulations and provide technical assistance to providers.

The activities of the Inspection of Care may include, but are not limited to:

1. Review of clinical documentation;
2. Client interviews;
3. Program review with staff;
4. Review of physical plant;
5. Review of provider policy and procedures;
6. Staff interviews;
7. Financial and payroll records; and
8. Employment records of staff qualification and training issues.

After an Inspection of Care, the IOC team will develop a report summarizing the findings of the visit. If deficiencies are noted, providers must submit a plan of correction.

35-015 (RESERVED)

35-016 (RESERVED)
35-017 Community Support: Substance Abuse Community Support is a rehabilitative and supportive service for individuals with primary Axis I Diagnosis of Substance Dependence. Community Support Interventions provide direct rehabilitation and support services to individuals in the community to assist the individual in maintaining abstinence, stabilizing community living, and preventing exacerbation of symptoms and admissions to more restrictive levels of care. This service is not available for individuals who are also receiving level III or greater substance abuse treatment services. Services are based upon medical necessity as identified in the client’s treatment and recovery plan and shall be provided in 15-minute increments.

35-017.01 Program Components: The Community Support Program shall:

1. Facilitate communication and coordination among all health care professionals providing services to the client;
2. Ensure completion of a strength-based needs assessment completion within 30 days of admission by the rehabilitation team or team member;
3. Develop and implement strategies to encourage the individual to become engaged and remain engaged in necessary substance use/abuse and mental health treatment services as recommended and included in the treatment/recovery plan;
4. Have access to the comprehensive substance use disorder assessment conducted by an independently licensed practitioner practicing within his/her scope updated within 30 days of admission into the program;
5. Participate with and report to the treatment and recovery team on the individual’s progress and response to community support intervention in areas of relapse prevention of substance use/abuse and application of education and skills in the recovery environment;
6. Review and update the treatment and recovery plan and discharge plan with the individual and other approved family supports every 90 days or more often as clinically necessary;
7. Coordinate with the providers of mental health when the client has a co-occurring diagnosis and receiving mental health services by a licensed practitioner either located in the agency or in a separate program;
8. Assist in facilitating the transfer to and the transition to other levels of treatment service;
9. Assist in the development, evaluation, and update in a crisis and relapse plan with the client;
10. Provide contact as needed with other providers, client family members and other significant individuals in the client’s life to facilitate communication necessary to support the individual in maintaining community living;
11. When prescribed, monitor medication compliance and report compliance issues as necessary;
12. Assist the client with all health insurance issues; and
13. Assist in the discharge plan for the client and support development of community-based resources.
35-017.02 Program Availability: The community support program shall establish hours of service delivery that ensure program staff availability and accessibility to the treatment, rehabilitation, and recovery needs of the client. The frequency of face-to-face contacts with the client is based upon clinical need.

35-017.03 Staffing Requirements: Community support programs shall employ a licensed practitioner to provide supervision of the community support program. The licensed practitioner shall supervise any individualized treatment and recovery service interactions provided by a community support worker. The Licensed Clinical Supervisor will review community support client’s clinical needs and progress toward their goals with the community support worker every 30 days. The review should be completed, preferably face-to-face. The review may be accomplished by the supervisor consulting with the community support worker on their assigned clients and providing clinical guidance or recommendations to better serve the client. The community support worker shall have a minimum of bachelor’s degree in psychology, sociology, or related human service field or two years of course work in a human service field and two years experience/training or two years of lived recovery experience with demonstrated skills and competencies in the provision of substance abuse services and demonstrated skill and competency in working with chronic substance dependence is acceptable.

Direct care staff employed by the agency before the effective date of these regulations will be considered to meet staffing requirements when the provider submits documentation identifying the name, address and provider number of the provider, service provided, names of direct care staff employed before the effective date of these regulations, and their date of hire. Documentation shall be submitted 30 days following the effective date of these regulations. Staff hired on or after the effective date of these regulations shall meet the specified requirements for direct care staff identified in the above paragraph;

35-017.04 Assessment and Treatment Planning: Outpatient substance abuse treatment shall be delivered following the completion of comprehensive substance abuse assessment. Prior to delivery of services, an individual treatment and recovery plan shall be developed with the client. The plan shall be individualized, reviewed and approved by the client and therapist, and adjusted as clinically necessary.

35-017.05 Documentation: Outpatient substance abuse treatment providers shall document in a summary the treatment service delivered in an individualized progress note. The note shall describe the treatment intervention provided, client's response to the intervention and the progress notes shall be placed in the client’s clinical record. Documentation shall clearly reflect the implementation of the treatment and recovery plan. Discharge planning shall be an essential part of the treatment and recovery plan and the documentation of the progress toward discharge shall be documented in the clinical record.

35-017.06 Provider Enrollment: Outpatient adult substance abuse providers shall contact the managed care entity when requesting approval in the managed care network as an adult substance abuse provider. Following approval, a substance abuse provider shall enroll as a provider of Medicaid services. Medicaid enrollment is necessary in order to complete credentialing process in the managed care network. Providers of outpatient services shall provide annual cost information as a requirement by Medicaid at the time of enrollment and maintain any licensure requirements in order to continue participation with Medicaid.
35-017.07 **Prior Authorization:** All outpatient substance abuse treatment services shall be prior authorized by the Division of Medicaid and Long-Term Care or its designee before treatment service delivery.

35-017.08 **Clients’ Rights:** Individual staff and the treatment and recovery team shall provide all services in a manner to support and maintain the client’s rights with a continuous focus on client empowerment and movement toward recovery. Providers shall have written Client Rights and Responsibility policy and staff shall review client rights, responsibilities, and grievance procedures with each new client at admission, at treatment and recovery plan review and at the request of the client. This review shall be documented in the clinical record. Substance Abuse Treatment providers shall comply with all State and Federal Clients’ Rights requirements.

Client rights shall be observed when receiving substance abuse services through Medicaid. The client has the right to:

1. Be treated with respect and dignity regardless of state of mind or condition;
2. Have privacy and confidentiality related to all aspects of care;
3. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
4. Be part of developing an individual treatment and recovery plan and decision-making regarding his/her treatment and rehabilitative services;
5. Refuse treatment or therapy (unless ordered by a mental health board or court);
6. Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;
7. Be free of any sexual exploitation or harassment;
8. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; and
9. Receive such forms, instructions and assistance as needed to file a complaint or request a state fair hearing.

35-017.09 **Payment for Community Support Abuse Treatment Services:** Providers shall bill community support services in 15-minute increments for a maximum of 144 units for 180 days.
36-000 MEDICAID HOSPICE BENEFIT

36-001 HOSPICE SERVICES: These regulations govern the Medicaid Hospice Benefit, a comprehensive package of services available to current Medicaid clients of all ages. Clients may voluntarily choose hospice services as the care option for their terminal illness. Hospice services include nursing services, physician services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services and pastoral care services. These services are offered based on individually assessed needs and choices of terminally ill clients and their families for palliative care and support.

36-002 DEFINITIONS:

Assisted living facility means a facility licensed as an assisted living facility by the Department of Health and Human Services Division of Public Health.

Attending physician means physician named by the client/representative in the hospice records. The attending physician has primary responsibility for the client’s care and treatment.

Caregiver means a friend, family member, or legal guardian who provides ongoing care for an individual who is unable to care for him/herself.

Center for developmental disabilities means a facility, including a group home, where shelter, food, and care, advice, counseling, diagnosis, treatment, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have developmental disabilities.

Client representative means a person who is, because of the client’s mental or physical incapacity authorized in accordance with state law to execute decisions about hospice services or terminate medical care on behalf of the terminally ill client.
**CMS** means the federal Centers for Medicare and Medicaid.

**Home health aide** means a person who is employed by a hospice to provide personal care, assistance with activities of daily living, and basic therapeutic care to the clients of the hospice.

**Homemaker** means person employed by, or a volunteer of, a hospice to provide domestic services including, but not limited to, meal preparation, laundry, light housekeeping, errands, and chore services as defined by hospice policy.

**Hospice or hospice service** means a person or legal entity which provides home care, palliative care, or other supportive services to terminally ill persons and their families.

**Hospice client** means a client who is diagnosed as terminally ill with a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course and who with informed consent is admitted into a hospice program.

**Hospice inpatient facility** means a facility in which the hospice provides inpatient care directly for respite and general inpatient care.

**Hospice interdisciplinary team** means the attending physician, hospice medical director, licensed professional registered nurse, certified social worker, pastoral or other counselor, and, as determined by the interdisciplinary plan of care, providers of special services such as counseling services, pharmacy services, home health aides, trained volunteers, dietary services, and any other appropriate health services, to meet the physical, psychosocial, spiritual, and economic needs which are experienced during the final stages of illness, dying, and bereavement.

**Hospice volunteer** means an individual specifically trained and supervised to provide support and supportive services to the hospice client and hospice client’s family under the supervision of a designated hospice volunteer coordinator. This does not apply to any volunteers working on behalf of a hospice licensed under the Health Care Facility Licensure Act who, as part of their volunteer duties, provide care.

**Institution for mental diseases** means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

**Intermediate care facility for mentally retarded** means a facility, licensed by the Department of Health and Human Services Division of Public Health and certified to participate in Medicaid, where shelter, food, and training or habilitation services, advice, counseling, diagnosis, treatment, care, nursing care, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have mental retardation or related conditions, including epilepsy, cerebral palsy, or other developmental disabilities.
Licensed medical nutrition therapist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Licensing Law and who holds a current license issued by the Department of Health and Human Services Division of Public Health pursuant to Neb. Rev. Stat. § 38-1813.

Licensed nurse means a person licensed as a Registered Nurse or as a Practical Nurse under the provisions of the Nurse Practice Act, Neb. Rev. Stat. §§ 38-2201 to 38-2236.

Medicaid means the Nebraska Medical Assistance Program established by Neb. Rev. Stat. § 68-903 and Title XIX of the Social Security Act.

Medicaid representative means the client’s services coordinator or case manager.

Medical director means a hospice employee or contracted person who is a doctor of medicine or osteopathy who is responsible for the overall coordination of medical care in the hospice.

Medication means any prescription or non-prescription drug or biological intended for treatment or prevention of disease or to effect body functions in humans.

Nursing facility means a facility or a distinct part of a facility, licensed by the Department of Health and Human Services Division of Public Health and certified for participation in the Medicaid program under Title XIX of the Social Security Act, where medical care, rehabilitation, or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled.

Palliative care means treatment directed at controlling pain, relieving other physical and emotional symptoms, and focusing on the special needs of the client and the client’s family as they experience the dying process rather than treatment aimed at a cure or prolongation of life.


Social worker, certified means a person who has received a baccalaureate or masters degree in social work from an approved educational program and holds a current certificate issued by the Department of Health and Human Services Division of Public Health.

Terminal illness means that the client is diagnosed with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course.

Treatment means a therapy, modality, product, device, or other intervention used to maintain well being or to diagnose, assess, alleviate, or prevent a disability, injury, illness, disease or similar condition.

Volunteer services means services provided by unpaid persons that supplement other covered services. Services include but are not limited to caregiver relief, short-term client companionship or running errands.
36-003 PROVIDER STANDARDS

36-003.01 Standards for Providing Services: The hospice provider shall deliver services in accordance with the following standards:

1. The needs, preferences, cultural diversity, values and expectations of client/caregiver are reflected in all aspects of service delivery;
2. All service provision is done in a manner that is empowering to the client/caregiver;
3. The client/caregiver feels safe and confident that their right to privacy is protected; and
4. The client/caregiver is treated with dignity and respect at all times.

36-003.02 Hospice Provider Requirements: To participate in the Medicaid program, the hospice provider shall:

1. Be a participant in the Medicare hospice program;
2. Be licensed to provide hospice care by the Department of Health and Human Services Division of Public Health;
3. Assume full responsibility for the professional management of the client’s hospice care;
4. Maintain certification by a physician that the client is terminally ill with a life expectancy of six months or less based on the physician’s or medical director’s clinical judgment regarding the normal course of the client’s illness;
5. Maintain the signed election statement in its files;
6. Develop the plan of care and interventions based on the assessment of the needs and choices identified by client/caregiver. All service provision shall be consistent with the plan of care;
7. Provide “on call” services 24 hours a day, seven days a week;
8. Follow all applicable Nebraska Department of Health and Human Services regulations;
9. Bill only for services authorized and actually provided;
10. Comply with the requirements of 471 NAC 3 for the submission of claims for payment;
11. Retain financial and statistical records for four years from date of service provision to support and document claims;
12. Accept Medicaid payment as payment in full from the Department of Health and Human Services plus the client’s share of cost;
13. Allow federal and state offices responsible for program administration or audit to review service and financial records. Inspections, reviews and audits may be conducted on site;
14. Operate a drug free work place;
15. Allow the Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place;
16. Agree and assure that any suspected abuse or neglect shall be reported to law enforcement and/or appropriate Department staff;
17. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60;

18. Agree and understand that any false claims (including claims submitted electronically), statements, documents, or concealment of material facts may be prosecuted under applicable state or federal laws (42 CFR 455.18); and

19. Respect every client’s right to confidentiality and safeguard confidential information.

36-003.03 Provider Agreement and Enrollment: The hospice provider shall complete and submit Form MC-19, “Medical Assistance Provider Agreement.” When the client resides in a facility, a copy of the hospice provider’s contract with the facility shall be attached.

36-004 CLIENT ELIGIBILITY REQUIREMENTS: The Medicaid Hospice Benefit is available to clients who meet the following criteria:

1. The client is currently eligible for Medicaid;
2. The client is diagnosed as terminally ill by the hospice medical director and the attending physician with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course; and
3. The client is an adult and has chosen to receive palliative/comfort care to manage symptoms of terminal illness and has chosen not to receive curative treatment or disease management; or
4. The client is a child and has elected to receive palliative/comfort care to manage symptoms of terminal illness. Such election by a child shall not constitute a waiver of any rights of the child to be provided with, or receive Medicaid payment for, concurrent services related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made.

36-005 COVERED SERVICES: The Medicaid Hospice Benefit includes coverage for services provided in response to the palliative management of the terminal illness. The hospice provider shall assure the following criteria are met:

1. All services shall be performed by qualified personnel;
2. The cultural requirements of the client/caregiver are identified and appropriate resources are utilized including interpreters; and
3. Services are provided based on the individual needs of client by staff educated in the hospice philosophy.

36-005.01 Nursing Services: The hospice provider shall assure that nursing services are provided by or under the supervision of a registered nurse. Nursing services shall be directed and staffed to assure that the nursing needs of the clients are met. The client care responsibilities of the nursing personnel shall be specified in the hospice plan of care. Services shall be provided in accordance with recognized standards of practice. Nursing services include:

1. Regular visits by a registered nurse (RN) or licensed practical nurse (LPN) to monitor condition, provide care, and maintain comfort based on assessment of individual needs and as identified in the hospice plan of care;
2. Face to face visits, at a minimum weekly by an RN/LPN, or more frequently as needed, and the registered nurse shall visit at least every two weeks;
3. Education based on the needs of the client/caregiver and family about the changes to be expected with the dying process; the appropriate use of medications, therapies, equipment, and supplies; what hospice does and does not do; and emphasis on the importance of realistic goals;
4. An initial assessment (see 471 NAC 36-005.01A);
5. An individualized hospice plan of care (see 471 NAC 36-005.01B); and
6. Coordination of care (see 471 NAC 36-005.01C).

36-005.01A Initial Assessment: An initial assessment shall be completed within 24 hours after Medicaid eligibility is established and the election statement is signed. The nurse completes the assessment to collect comprehensive information concerning the client’s preferences, goals, health status, and to determine strengths, priorities, and resources. The assessment shall be completed by a designated registered nurse from the hospice provider and coordinated with the client’s Medicaid representative. Ongoing assessments shall be completed and updated with each client visit.

36-005.01B Individualized Hospice Plan of Care: An individualized hospice plan of care shall be written to identify specific individual services to be provided in a coordinated and organized manner. The interdisciplinary team shall be involved in developing the plan of care. The hospice plan of care shall be culturally appropriate and identify in detail the services that shall address the needs identified in the assessment. The hospice plan of care shall state in detail the scope and frequency of services that shall meet the client’s and family’s needs. The hospice plan of care shall be developed with the client/caregiver within two calendar days of admission to the hospice program. The care provided shall be in accordance with the written plan of care. In the event of disagreement between the client and in-home caregiver, the client shall make the final decision about care, service needs, preferences, and choices. The hospice plan of care shall be reviewed and updated based on client need and a minimum of every two weeks.

36-005.01C Coordination of Care: Coordination of care shall include links to needed services and resources, and shall ensure that client choices and concerns are represented. The hospice provider shall designate a registered nurse to coordinate the implementation of the hospice plan of care with the client’s Medicaid representative. Coordination shall accomplish sharing of information to prevent gaps in service, duplication of services and duplication of payment. A request for additional Medicaid services or a determination of denial of hospice services for a Medicaid client by the hospice provider shall be coordinated with the client’s Medicaid representative. The hospice provider shall notify the client’s Medicaid representative when a Medicaid client elects hospice services.

36-005.02 Home Health Aide/Homemaker: The hospice provider shall assure that home health aide/homemaker services are provided to promote client care and comfort and are completed at the direction of the client/caregiver based on client's individualized hospice
plan of care. Services shall be available and adequate to meet the needs of the client. Home health aide/homemaker services include:

1. Personal care services, for example, bathing, dressing, assisting with bowel and bladder requirements, assisting with ambulating, hair care, nail care, as indicated in the client’s individualized hospice plan of care and at the direction of the client/caregiver; and
2. Homemaker services to maintain a safe and sanitary environment, for example, meal preparation, changing linens, light housekeeping and laundry for client cleanliness and comfort, as indicated in client's individualized hospice plan of care and at the direction of the client/caregiver.

36-005.03 Medical Social Services: The hospice provider shall assure that medical social services are provided for the client/caregiver and family under the direction of the physician. Medical social services include:

1. Crisis intervention for the client, caregiver, and/or family;
2. Psychosocial assessment to address needs identified by the client/caregiver and to develop plans for intervention;
3. Counseling to assist the client/caregiver/family, including children, cope with serious illness/death;
4. Client advocacy to assure the client/caregiver have choices in care and understand their right to refuse treatment;
5. Liaison between client and needed community resources;
6. Fostering human dignity and personal worth; and
7. Coordination of services with the Medicaid representative, when applicable.

36-005.04 Medical Equipment and Supplies including Drugs and Biologicals: The hospice provider shall assure that medical equipment and supplies, including drugs, are provided for palliation and management of the terminal illness and related conditions. All equipment, supplies, medications, and biologicals shall be provided as prescribed by the client's physician, as needed, and at the direction of the client/caregiver as indicated in the client’s individualized hospice plan of care. These services include:

1. Medication for the relief of pain and related symptoms;
2. Durable medical equipment related to palliation; and
3. Personal comfort items needed for client comfort and management of terminal illness.

36-005.05 Other Counseling Services: The hospice provider shall assure that other counseling services are available for the client, caregiver, and family. Services include:

1. Dietary counseling provided by a licensed medical nutrition therapist;
2. Spiritual counseling with a person of the client’s choice. The interdisciplinary team shall include pastoral care professionals who are educated in the hospice philosophy;
3. Bereavement counseling provided through an organized program of bereavement services under the supervision of a qualified professional.
Bereavement services shall be offered to the client’s family at least quarterly for one year following death of the client. Bereavement services shall identify “at risk” survivors and provide resources for follow-up. It is the choice of the family to accept bereavement services.

36-005.06 Volunteer Services: The hospice provider shall sponsor a volunteer program and shall assure that volunteers participate in an initial volunteer education program. Opportunities for ongoing education shall be available for volunteers.

36-005.07 Physician Services: The client’s attending physician or a physician associated with the hospice provider shall provide medical direction. The physician associated with the hospice provider shall ultimately assure the general medical needs are met in all settings, including long term care.

36-005.08 Physical Therapy, Occupational Therapy, and Speech Language Pathology Services: The hospice provider shall assure that physical therapy, occupation therapy, and speech language/pathology services are provided to control symptoms or to enable the client to maintain activities of daily living and basic functional skills. These services shall be provided under the direction of the physician and shall be included in the hospice plan of care. The client/caregiver makes the final decision regarding acceptance/refusal of a therapy program.

36-005.09 Medical Interventions: The hospice provider shall assure that medical interventions are provided when the interventions related to the terminal illness, either in use or planned, have been evaluated by the attending physician, hospice medical director, hospice team, client/caregiver, and family, based on the quality of life, value of the treatment to the client, and the service’s congruence with the palliative care goals of the client/caregiver, family, and hospice. Planned interventions shall be included in the hospice plan of care.

36-006 ELECTION OF HOSPICE SERVICES: A client or the client’s legal representative shall file a voluntary, written expression to choose hospice care, called an election statement designating the Medicaid Hospice Benefit as the care preference for terminal illness. The election statement shall include:

1. The date that hospice services are to begin;
2. The name of the hospice provider; and
3. The client’s signature or the signature of the client’s legal representative when client is unable to sign. The reason the client cannot sign shall be documented.

A client who has Medicare coverage shall use Medicare coverage as primary payer until Medicare benefits are exhausted. Medicaid pays the Medicare co-insurance and deductible when the client is covered by both Medicare and Medicaid. See 471 NAC 3-004.

36-006.01 Hospice’s Responsibilities at Election: When a client elects to receive hospice services, the hospice program shall:

1. Explain the benefits the client shall receive;
2. Explain the benefits the client is waiving;
3. Give the client or legal representative a copy of the signed statement; and
4. Retain the signed statement in its files.

36-006.02 Benefit Periods: Medicaid provides two 90-day benefit periods during the client’s lifetime. If additional benefit periods are needed, Medicaid provides three 60-day benefit periods. Hospice services beyond these benefit periods shall be approved as an exception under the prior authorization provisions in 471 NAC 36-007. The benefit periods may be used consecutively or at intervals.

36-006.02A Certification: The client shall be certified as terminally ill with a six-month life expectancy by the hospice medical director and the attending physician at the beginning of the first benefit period and by the hospice medical director for all subsequent benefit periods.

36-006.03 Waiver of Medicaid Benefits for Adult Clients: An adult client shall be deemed to have waived all rights to Medicaid payment for treatment associated with the terminal illness for the duration of the election of hospice care. Medicaid services provided for conditions/illnesses that are unrelated to the terminal illness may be covered by Medicaid separate from the hospice benefit. These services shall be based on individual assessed need and medical necessity as specified in the appropriate chapters of Title 471. If the client/representative revokes election of the Medicaid Hospice Benefit, Medicaid coverage of the benefits deemed to have been waived is restored.

36-006.04 Revocation of Election of Hospice Benefit: A client/representative may revoke election of the hospice benefit at any time. The days that are remaining in the current benefit period are lost. The client/representative shall initiate the process of revocation and follow through with the hospice provider.

The client may initiate re-election of the Medicaid Hospice Benefit if eligibility criteria are met.

36-006.05 Change of Hospice: The client/representative may choose to change from one hospice provider to another hospice provider. A change of hospice may occur only once in each benefit period.

36-007 PRIOR AUTHORIZATION: All hospice services shall be prior authorized. The hospice shall submit prior authorization requests to the Department within 72 hours of the initial assessment. Prior authorization may be retroactive for up to seven days, based on the client’s entry date into the hospice program. To request prior authorization, the hospice shall submit:

1. Agency name and provider number;
2. Signed election statement;
3. Physician certification of terminal illness and 6 month or less life expectancy;
4. Hospice plan of care; and
5. List of all medications, biologicals, supplies, and equipment for which the hospice is responsible.
Claims may be denied when prior authorization is not completed.

Re-authorization shall be requested for clients who surpass the six-month prognosis.

36-007.01 Clinical Criteria for Non-Cancer Diagnosis: Coverage of the Medicaid Hospice Benefit depends on a physician’s certification that an individual’s prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. The client shall be discharged from the Medicaid Hospice Benefit when the client improves or stabilizes enough that the six months or less prognosis is no longer accurate. The client may be re-enrolled for a new benefit period when a decline in the clinical status is such that the life expectancy is again six months or less.

36-007.01A Guidelines for Decline in Clinical Status: Clients shall be considered to have a life expectancy of six months or less only when there is documented evidence of a decline in clinical status. Baseline data is established on admission to hospice through nursing assessment in addition to utilization of existing information from records. It is essential that baseline and follow-up determinations are documented thoroughly to establish a decline in clinical status.

Coverage of hospice care for clients not meeting the guidelines may be denied. Some clients may not meet the guidelines, yet still be appropriate for hospice care, because of co-morbidities or decline. Coverage for these clients may be approved through the prior authorization process.

36-008 MEDICAID HOSPICE BENEFIT IN CERTAIN FACILITIES: A client who meets the eligibility requirements in 471 NAC 36-004 and resides in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), a Nursing Facility (NF), an Institution for Mental Disease (IMD), an Assisted Living Facility (ALF), or a Center for the Developmental Disabilities (CDD) may elect to receive hospice services where s/he lives. The Medicaid Hospice Benefit is available to Medicaid eligible persons in an IMD who are age 20 or younger or 65 or older. The facility shall agree to the provision of hospice services and the hospice provider shall have a signed contract with the facility before provision of hospice services.
36-008.01 Facility’s Responsibilities: The facility shall:

1. Provide room and board for the client;
2. Perform personal care;
3. Assist with activities of daily living;
4. Administer medications;
5. Provide social activities;
6. Provide housekeeping;
7. Supervise and assist with the use of durable medical equipment and prescribed therapies; and
8. Develop plan of care in collaboration with the hospice provider, client/caregiver and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the plan.

36-008.02 Hospice Responsibilities: The hospice provider shall:

1. Assess the client’s needs in coordination with the designated facility representative and client/caregiver;
2. Develop a hospice plan of care in collaboration with client/caregiver, facility caregivers and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the hospice plan of care;
3. Assume the professional management responsibility for ensuring the implementation of the hospice plan of care at the direction of the client/caregiver;
4. Coordinate, with the facility’s representative, the responsibilities of the facility and the responsibilities of the hospice provider and document in all client records;
5. Involve family and facility personnel in assisting with provision of services as designated by the hospice plan of care, and at the direction of the client/caregiver. The same level of services that would be provided in the home shall be provided in the facility; and
6. Provide social services and counseling utilizing hospice personnel. This service may not be delegated to the facility’s personnel.

The hospice provider may not require the client to move from the facility as long as the client’s needs can be appropriately and safely met.

36-009 WAIVERS: Clients who elect the hospice benefit while receiving home and community-based (HCB) waiver services may continue to receive HCB waiver services that are based on assessed need and medical necessity. All medical services related to the terminal illness or the hospice plan of care are the responsibility of the hospice and all services shall be coordinated with the waiver services coordinator. The waiver services coordinator retains full responsibility for waiver planning and service authorization.
36-010 DISCHARGE GUIDELINES: The hospice provider shall discontinue services for a client when:

1. The home environment is not safe for hospice personnel, caregiver, or client;
2. The client no longer meets admission guidelines;
3. Life expectancy exceeds one year of benefit periods;
4. The client revokes hospice election; or
5. The client is no longer Medicaid eligible.

36-011 QUALITY ASSURANCE: The Department of Health and Human Services may refuse to execute or may cancel a contract/provider agreement with a hospice provider when the hospice provider:

1. Does not meet the hospice requirements in 471 NAC 36-000;
2. Consistently admits clients who do not meet the eligibility requirements for terminal illness or consistently exceed the six-month prognosis;
3. Consistently refuses to provide or is unable to provide services identified in the assessment and on the hospice plan of care;
4. Consistently bills the majority of claims at the “Continuous Home Care” rate; or
5. Consistently discharges clients in conflict with 471 NAC 36-000.
36-012 PAYMENT: Medicaid pays for services provided under the Medicaid Hospice Benefit using the Medicaid hospice payment rates established by CMS.

36-012.01 For adult clients: Medicaid pays the inpatient respite care rate to the Hospice provider for each day the client is in an inpatient facility (hospital or nursing facility) and receiving respite care (see 471 NAC 36-012.03).

Medicaid pays the general inpatient care rate to the Hospice provider during a period of acute medical crisis (See 471 NAC 36-012.04). Payment shall be made only when the care is provided in a hospital or a contracted hospice inpatient facility.

Medicaid pays all costs for hospital services provided when a client receiving the Medicaid Hospice Benefit is hospitalized for an acute medical condition that is not related to the terminal diagnosis and/or complications secondary to the terminal diagnosis.

Determination of the cause of hospitalization shall be made by the Hospice disciplinary team with consultation with the Medicaid Hospice Program Specialist. Payment for hospital services shall be made directly to the hospital.

36-012.02 For child clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility, including Inpatient Respite Care (see 471 NAC 36-012.05) and General Inpatient Care (see 471 NAC 36-012.06).

36-012.03 Routine Home Care: Medicaid pays the routine home care rate to the hospice provider for every day the client is at home, under the care of hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

36-012.04 Continuous Home Care: Medicaid pays the continuous home care rate to the hospice provider to maintain a client at his/her place of residence when a period of medical crisis occurs. A period of medical crisis is a time when a client requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. A registered nurse or a licensed practical nurse shall provide nursing care. A nurse shall be providing more than one half (51% or greater) of care given in a 24-hour period. A minimum of eight hours of care shall be provided in a 24-hour period, which begins and ends at midnight. When the number of hours is less than 24, Medicaid pays the hourly rate. The hours may be split over the 24 hours to meet the needs of the client. Routine home care shall be billed when fewer than eight hours of nursing care are provided.

36-012.05 Inpatient Hospital or Nursing Facility Respite Care: For adult clients, Medicaid pays the inpatient respite care rate to the hospice provider for each day the client is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the client when necessary to relieve the caregiver. Payment may be made for a maximum of five days per month counting the day of admission but not the day of discharge. The discharge day for inpatient respite care is billed at routine home care unless the client is discharged as deceased. When the client dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Inpatient respite care is not paid when the client is residing in a facility listed in 471 NAC 36-008.
36-012.06 General Inpatient Care: For adult clients, Medicaid pays the general inpatient care rate to the hospice provider during a period of acute medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management that cannot be provided in any other setting. Care shall be provided in a hospital or a contracted hospice inpatient facility that meets the hospice standards regarding staffing and client care. When a severe breakdown in caregiving occurs, the general inpatient care rate shall be paid until other arrangements can be made, up to a maximum of ten days per month. The discharge day for general inpatient care is billed as routine home care unless the client is discharged as deceased. When the client dies under general inpatient care, the day of death is paid at the general inpatient care rate.

36-012.06A Limitation On Payments To A Hospice: Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid clients during that same period. Medicaid clients who have been diagnosed with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospice’s “cap period” (11/1 -10/31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate are not counted as inpatient days. The Department calculates the limitation as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.
2. If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment is necessary.
3. If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:
   a. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made;
   b. Multiplying excess inpatient care days by the routine home care rate;
   c. Adding together the amounts calculated in a and b; and comparing the amount in c with interim payments made to the hospice for inpatient care during the “cap period.” Any excess reimbursement is refunded by the hospice.

36-013 PAYMENT FOR SERVICES RECEIVED IN FACILITIES:

36-013.01 For adult clients: Medicaid pays the hospice provider for both the hospice services provided and for the residential services provided by the facility.
36-013.01A Payment for the Medicaid Hospice Benefit When Provided in an ICF/MR, Nursing Facility, or IMD: Residential payment is 95% of the rate that would have been paid to the facility for residential services.

36-013.01B Payment and Medicaid Managed Care: When the Medicaid Hospice Benefit is elected by the client who is participating in the Nebraska Health Connection (Medicaid Managed Care), services not covered in the Medicaid Hospice Benefit are covered as part of the benefits of the managed care plan, as provided in Title 471 and 482.

36-013.02 For child clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility.

36-014 BILLING: The hospice provider shall bill for services provided using Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For claim submission instructions, see the Claim Submission Table at 471-000-49.

HCPCS/CPT procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Fee Schedule (see 471-000-536).

36-015 MEDICAID PAYMENT WHEN A MEDICAID CLIENT RESIDING IN A NURSING FACILITY OR ICF/MR ELECTS THE MEDICARE HOSPICE BENEFIT: See 471 NAC 12-015.
CHAPTER 37-000  PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

37-001  INTRODUCTION: This chapter regulates Nebraska’s Program of All-Inclusive Care for the Elderly (PACE) provided under Nebraska Medicaid.

37-001.01 Definitions:

**Appeal:** The process by which a participant may seek and obtain a review and reversal with respect to enrollment denial; involuntary disenrollment; or non-coverage of, or nonpayment for, a service including denials, reductions, or termination of services.

**External appeal:** The State Administering Agency’s or Medicare’s formal appeal processes.

**Grievance:** A complaint, either written or oral, by participants, their family members, and/or representatives expressing dissatisfaction with service delivery or the quality of care furnished.

**Internal appeal:** A PACE organization’s appeal process.

**PACE organization:** An entity that has a PACE program agreement in effect to operate a PACE program.

**PACE program:** A program of all-inclusive care for the elderly that is operated by an approved PACE organization and that provides comprehensive healthcare services to PACE participants in accordance with a PACE program agreement.

**PACE program agreement:** An agreement between a PACE organization, CMS, and the State Administering Agency for the operation of a PACE program.

**Participant:** An individual who is enrolled in a PACE program.

**Premium:** The monthly amount that a PACE organization charges a participant as determined by the participant’s eligibility status for Medicare and Medicaid pursuant to 42 CFR 460.186.

**State Administering Agency (SAA):** The State agency responsible for administering the PACE program agreement. In Nebraska the SAA is the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.
37-001.02 Legal Basis: PACE is authorized by Sections 1894 and 1934 of the federal Social Security Act. Federal PACE regulations are located at 42 CFR, Part 460.

37-002 PARTICIPANT ELIGIBILITY

37-002.01 Eligibility Criteria: Participation in PACE is voluntary. PACE eligibility criteria include the following:

1. Be 55 years of age or older;
2. Meet the nursing facility level of care (NF LOC) criteria (See 471 NAC 12);
3. Live in the service area of the PACE organization; and
4. Be able to safely live in a community setting, at the time of enrollment, with PACE services.

37-002.02 Eligibility Determinations: The PACE organization shall be responsible for determining eligibility based on the criteria set forth in section 37-002.01 of this chapter.

37-002.03 Denial of Eligibility: A potential participant shall be denied enrollment if he/she does not meet the eligibility criteria as set forth in section 37-002.01 of this chapter.

37-002.03A Nursing Facility Level of Care Not Met: If a potential participant does not meet NF LOC, the SAA will notify the PACE organization, and the potential participant shall receive a notice of adverse action. Upon receipt of adverse action, potential participants may appeal using the SAA’s appeal process (See 465 NAC 2-001.02).

37-002.03B Unsafe: If a potential participant is determined to be unable to safely live in a community setting, the PACE organization shall:

1. Notify the potential participant in writing of the reason for the denial;
2. Refer the potential participant to alternative services, as appropriate;
3. Maintain supporting documentation of the reason for the denial; and
4. Notify CMS and the SAA and make the documentation available for review.

37-002.03B1 Appeal Process: Upon receipt of the PACE organization’s written denial based on the inability to safely live in the community, potential participants have the right to appeal using the SAA’s appeal process (465 NAC 2-001).

37-002.03C Appeal Process for Medicare-only Beneficiaries: Medicare does not have an appeal process that permits challenges of enrollment denials for Medicare-only beneficiaries within PACE. Medicare-only eligible participants, as well as private pay participants, must use the appeals process provided by the SAA (71 Fed. Reg. 71244, 71303, 71312, 71317 (Dec. 8, 2006)).

37-002.04 Annual Nursing Facility Level of Care Recertification: A PACE participant’s NF LOC shall be documented by the PACE organization and recertified by the SAA within 12 months of each previous recertification.
37-002.05 Waiver of Annual Nursing Facility Level of Care Recertification: The annual recertification requirement may be permanently waived by the SAA at the PACE organization’s request. The PACE organization shall provide to the SAA the participant’s diagnosis, medical record and plan of care for review for waiver and will be notified of the SAA’s determination.

37-002.06 Deemed Continued Eligibility: If a participant no longer meets NF LOC at the time of annual recertification, he/she may be allowed to continue eligibility until the next annual recertification upon the request of the PACE organization. The PACE organization shall provide information to the SAA to be reviewed under the following criteria:

1. The participant can reasonably be expected to meet NF LOC eligibility again within six months in the absence of continued coverage under the program; and
2. The participant’s medical record and plan of care support continued eligibility.

37-003 PARTICIPANT ENROLLMENT

37-003.01 Participant Enrollment: A PACE organization shall receive direct inquiries from potential participants. The PACE organization shall verify that the potential participant meets all eligibility criteria as set forth in section 37-002 of this chapter.

37-003.02 Duration of Enrollment: Enrollment continues until the PACE participant’s death, regardless of changes in health status, unless the participant voluntarily disenrolls or is involuntarily disenrolled by the PACE organization under section 37-006.01 or 37-006.02 of this chapter.

37-004 PACE BENEFITS

37-004.01 Benefits: The PACE benefit package for all participants, regardless of source of payment, shall include the following:

1. All Medicare-covered items and services;
2. All Medicaid-covered items and services as specified in Nebraska’s approved Medicaid State Plan; and
3. Other services determined necessary by the PACE organization’s interdisciplinary team to improve and maintain the participant’s overall health status.

37-004.02 Benefit Conditions: If a Medicare beneficiary or Medicaid recipient chooses to enroll in the PACE program, the following conditions apply:

1. Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply (Note: Participants who have been determined to have a Medicaid share of cost remain responsible to meet their share of cost as per 469 NAC 4); and
2. The participant, while enrolled in the PACE program, shall receive all Medicare and Medicaid benefits, as well as other services determined necessary by the PACE organization interdisciplinary team, solely through the PACE organization.

37-004.03 Excluded Benefits: The following services are excluded from coverage under PACE:

1. Any service that is not authorized by the interdisciplinary team.
2. In an inpatient facility, a private room and private duty nursing services, unless medically necessary, as well as non-medical items for personal convenience unless specifically authorized by the interdisciplinary team as part of the participant’s plan of care.
3. Cosmetic surgery, not including surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
4. Experimental medical, surgical, or other health procedures.
5. Services furnished outside of the United States, including the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, except under particular circumstances and as permitted under the Medicaid State Plan.

37-005 PARTICIPANT RIGHTS

37-005.01 Written Explanation: Upon enrollment, a PACE participant shall be informed, in writing, of his/her rights and responsibilities and all rules and regulations governing participation according to 42 CFR 460.110 and 460.112.

37-005.02 Grievance Process: Upon enrollment and at least annually thereafter, the PACE organization supply participants written information about its grievance process. In the event of a grievance, the PACE organization shall:

1. Discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant’s grievance;
2. Continue to furnish all required services to the participant during the grievance process.

37-005.03 Appeal Processes for Non-Coverage or Non-Payment of a Service: The PACE organization shall give enrolled participants written information on available appeal processes upon enrollment, at least annually thereafter, and whenever a participant takes action with respect to the PACE organization’s non-coverage or non-payment of a service including denials, reductions, or terminations of services. (See section 37-002.04 of this chapter for appeals of denial of enrollment and section 37-006.04 of this chapter for appeals of involuntary disenrollments.)

37-005.03A Available Appeal Processes:

1. The PACE organization’s internal appeal process.
2. The SAA’s appeal process (external appeal process).
3. Medicare’s appeal process through the Independent Review Entity (IRE) that contracts with CMS (external appeal process).

37-005.03B PACE Organization Internal Appeal Process: Participants shall first access the PACE organization’s internal appeal process prior to using the SAA’s or Medicare’s appeal process for all decisions pertaining to non-coverage of, or non-payment for, a service including denials, reductions, or terminations of services.

37-005.03C PACE Organization Third Party Review: The PACE organization must appoint an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the participant’s appeal.

37-005.03C1 Notice of Internal Appeal Outcome: The PACE organization shall notify a participant of the outcome of his/her appeal in writing no later than 30 calendar days after the organization receives the verbal or written appeal, unless the appeal has been expedited as described in section 37-005.03C2 of this chapter.

37-005.03C2 Expedited Appeal Process: A PACE organization shall have an expedited appeal process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the services in dispute.

37-005.03C2a Expedited Appeal Notice: The PACE organization must respond in writing to an expedited appeal no later than 72 hours after it receives the appeal.

37-005.03C2b Expedited Appeal Extension: The PACE organization may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:

1. The participant requests the extension; or
2. The PACE organization justifies to the SAA the need for additional information and how the delay is in the interest of the participant.

37-005.03C3 Favorable Determination: If a determination is made in favor of the participant on appeal, the PACE organization must furnish the disputed service as expeditiously as the participant’s health condition requires.

37-005.03C4 Adverse Determination: For a determination that is wholly or partially adverse to a participant, the PACE organization must notify the participant, the SAA, and CMS.

37-005.03D External Appeals: If dissatisfied with the outcome of their internal appeal to the PACE organization, participants may appeal as follows:
37-005.03D1 Participants Eligible for Both Medicaid and Medicare: Participants who are eligible for both Medicare and Medicaid have the choice of using either the SAA’s or Medicare’s appeal process; however, they may only choose one route by which to exercise their external appeal rights. The PACE organization shall assist the participant in choosing which process to pursue if both are applicable, and the PACE organization must forward the appeal to the appropriate external agency.

37-005.03D2 Participant Eligible Only for Medicare: Participants who are only eligible for Medicare shall appeal through the Independent Review Entity (IRE).

37-005.03D3 Participants Eligible Only for Medicaid: Participants who are only eligible for Medicaid shall appeal using the SAA’s appeal process.

37-005.03D4 Private Pay Participants: Participants who are private pay shall appeal using the SAA’s appeal process.

37-005.03E Services Provided During the Appeals Process: During the appeals process, the PACE organization shall continue to provide non-disputed services to a participant.

37-005.03E1 Medicaid Recipient: For a participant who is a Medicaid recipient, the PACE organization shall continue to provide the disputed service until the final determination is issued if the following conditions are met:

1. The PACE organization is proposing to terminate or reduce a service currently being furnished to the participant; and
2. The participant requests continuation of the provision of services with the understanding that he or she may be liable for the cost of the contested services if the determination is not made in his/her favor.

37-006 PARTICIPANT DISENROLLMENT

Reasons for disenrollment, either voluntary or involuntary, shall be documented by the PACE organization.

37-006.01 Voluntary Disenrollment: A participant may voluntarily disenroll from the program without cause at any time, including if he/she no longer meets NF LOC criteria.

37-006.02 Involuntary Disenrollment: A PACE organization may involuntarily disenroll a participant for any of the following reasons:

1. The participant fails to pay, or make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.
2. The participant engages in disruptive or threatening behavior. Disruptive or threatening behavior is either of the following:
   a. Behavior that jeopardizes a participant’s health or safety or the safety of others; or
   b. Consistent refusal to comply with an individual plan of care or the terms of the PACE enrollment agreement while having decision-making capacity.

3. The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

4. The participant is determined to no longer meet nursing facility level of care and is not deemed eligible under section 37-002.06 of this chapter.

5. The PACE organization’s agreement with CMS and the SAA is not renewed or is terminated.

6. The PACE organization is unable to offer required services because of the loss of State licenses or outside provider contracts.

37-006.02A SAA Review and Final Determination: Before an involuntary disenrollment is effective, it shall be reviewed by the SAA and a determination made that acceptable grounds for disenrollment have been documented by the PACE organization.

37-006.02B Reinstatement in PACE: A previously disenrolled PACE participant may re-enroll but shall do so as a new applicant.

A participant scheduled to be disenrolled for failure to pay his/her premium may be reinstated with no break in coverage if payment is made prior to the effective date of disenrollment. If payment is received after the effective date of disenrollment, the participant shall re-enroll as a new applicant.

37-006.03 Transition from PACE: Upon either voluntary or involuntary disenrollment, the PACE organization shall:

   1. Facilitate a participant’s reinstatement in other Medicare and Medicaid programs for which the participant is eligible;
   2. Coordinate the disenrollment date between Medicare and Medicaid for participants who are eligible for both programs;
   3. Give reasonable advance notice of the disenrollment date to the participant; and
   4. Continue to furnish all needed services as identified in the participant’s plan of care until the disenrollment date.

37-006.03A Effective Date: The participant shall be allowed to continue to use PACE organization services and will remain liable for any premiums due until the disenrollment date.

37-006.04 Appeals of Involuntary Disenrollment: Participants who are involuntarily disenrolled may appeal using the SAA’s appeal process (465 NAC 2-001).
37-006.04A Appeal Process for Medicare-only Beneficiaries: Medicare does not have an appeals process that permits challenges of disenrollment determinations of Medicare-only beneficiaries within PACE. Medicare-only eligible participants, as well as private pay participants, must use the appeals process provided by the SAA (71 Fed. Reg. 71244, 71303, 71312, 71317 (Dec. 8, 2006)).

37-007 PACE ORGANIZATIONS

37-007.01 Agreement: PACE organizations shall have an agreement with CMS and the SAA for the operation of a PACE program. The agreement specifies the prospective monthly capitated Medicaid payment amount as negotiated by the PACE organization and the SAA. The monthly capitated payment may be renegotiated on an annual basis as pursuant to 42 CFR 460.182.

37-007.02 Licenses or Credentials: PACE organizations must hold appropriate licenses or credentials as required under state licensing laws.

37-007.03 Federal Requirements: In addition to the requirements in this chapter, PACE organizations must also meet all applicable federal requirements, including those set forth in 42 CFR, Part 460.
38-000  ESTATE RECOVERY

38-001  Scope and Authority: Medicaid estate recovery is mandated by §1917(b) of the Social Security Act. State statutory requirements are set forth in Neb. Rev. Stat. §68-919.

38-002  Definitions: The following definitions apply for purposes of Medicaid estate recovery:

Claim means the total amount of medical assistance paid after July 16, 1994 for a recipient when the recipient was fifty-five years of age or older or during a period of institutionalization as described in 471 NAC 38-003.

Estate means all real and personal property and other assets included within the Medicaid recipient’s estate as defined for purposes of state probate law.

Medical institution means a skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, nursing facility, inpatient hospital or residential treatment center.

Qualified Long-Term Care Partnership Policy means a long-term care insurance policy that has been approved by the Nebraska Department of Insurance.

Recipient means an individual who has received Medicaid benefits.

38-003  Estate Recovery Criteria: The Department of Health and Human Services has a claim for medical assistance paid against Medicaid recipients who meet the following criteria:

1. The recipient was fifty-five years of age or older at the time medical assistance was provided or the recipient resided in a medical institution and, at the time of institutionalization or application for medical assistance, whichever is later, the Department determines the recipient could not have reasonably been expected to be discharged and resume living at home.

2. The recipient is not survived by a spouse or a child who is either under age twenty-one or blind or totally and permanently disabled as defined by the Supplemental Security Income criteria.

38-004  Undue Hardship

38-004.01  Purpose: Waivers granted by the Department based on undue hardship are intended to prevent the impoverishment of the deceased recipient’s family if the Department were to pursue its estate recovery claim. The fact that family members anticipate or expect an inheritance or may be inconvenienced economically by the lack of an inheritance is not a valid basis for an undue hardship waiver.
38-004.02 Criteria: Any of the following circumstances may constitute an undue hardship and may result in a full or partial compromise of claim:

1. An heir of the recipient resided in the recipient’s home for two years prior to the recipient’s entry into a nursing home and the heir provided the type of unreimbursed care that delayed the recipient’s entry into a nursing home;
2. An heir of the recipient resided in the recipient’s home for two years prior to the recipient’s receipt of recoverable medical services and the heir provided unreimbursed care that delayed the recipient’s receipt of those services;
3. Payment of the Department’s claim would cause heirs of the deceased recipient to be eligible for public assistance;
4. Waiver of the Department’s claim would allow an heir to discontinue eligibility for public assistance for a substantial time period; or
5. Other situations which the Department, in its discretion, determines constitutes an undue hardship on the heirs.

38-004.03 Limitations: Any heir of the estate of a Medicaid recipient may apply for waiver of the estate recovery claim based on undue hardship. Any claim may be waived by the Department, partially or fully. An undue hardship does not exist if action taken by the recipient, or by his or her legal representative or heirs, divested or diverted assets from the estate. The Department may grant undue hardship waivers on a case by case basis upon consideration of all the facts and circumstances including any action taken to divert or shelter assets available for estate recovery or to avoid estate recovery.

38-004.04 Application and Review Process: A waiver applicant must have a beneficial interest in the estate and must apply for a waiver in writing within thirty days from the creditor’s claim filing deadline or ninety days from the recipient’s date of death if the estate is not probated. The written application must include:

1. A statement of the applicant’s relationship to the recipient with supporting documentation; and
2. A statement of the basis for the hardship waiver under 471 NAC 38-004.02 with supporting documentation.

The Department must review each application and issue a written decision within ninety days after the Department’s receipt of the application. The Department’s written decision must advise the applicant of the procedure for requesting an administrative hearing should the applicant want to appeal the Department’s decision.
38-005 Long-Term Care Partnership Program: Neb. Rev. Stat. Section 68-1095.01 established Nebraska’s Long-Term Care Partnership Program.

Resources equal to the amount of benefits paid out by a long-term care partnership policy are disregarded for an individual applying for Medicaid if the policy was issued on July 1, 2006 or later and the individual is otherwise Medicaid eligible. The amount of the resource disregard is also excluded from estate recovery.

The Department accepts the Department of Insurance’s approval of the policy.

38-005.01 Reciprocity with Other States: The Department will accept partnership policies issued in other states with Qualified Long-Term Care Partnership Programs.
CHAPTER 41-000  MEDICAL SERVICES COVERED BY CHILD WELFARE FUNDS

41-001  Introduction: This chapter deals with medical services that are covered by child welfare funds.

For Medicaid services, see Chapters 1-000 through 31-000 of Title 471.

41-001.01  Legal Basis: Title IV, Part B of the Social Security Act authorizes the states to provide child welfare services. Section 43-284, Reissue Revised Statutes of Nebraska, authorizes the Nebraska Department of Social Services to provide medical and psychiatric services to Department wards. The children may be removed from their homes or placed in their own homes with the provision of services and supervision.

The Department of Social Services provides all services in accordance with the Family Policy Act, Sections 43-532 through 43-534, R.R.S., 1943.

41-001.02  Purpose: The program ensures proper authorization and delivery of medical services to a child, and the child's family when services will benefit the child, when -

1. The child is committed to the custody of the Nebraska Department of Social Services by virtue of a court order entered by a court of competent jurisdiction;
2. The child's guardianship is surrendered to the Department by a properly executed voluntary relinquishment; or
3. The child's custody is transferred to the Department through a "Voluntary Placement Agreement" (see 474 NAC 5-021.22 ff.).

41-001.03  Administration: The program is administered by the Nebraska Department of Social Services in accordance with state laws and with rules, regulations, and procedures established by the Director of the Nebraska Department of Social Services.

41-001.04  Definitions: For use within this program, the following definitions of terms will apply unless the context in which the term is used denotes otherwise.

  Child Welfare Funds: State funds that may be used to meet the needs of -

1. Department wards;
2. Former wards;
3. Children who are eligible for adoption assistance; and
4. Subsidized guardians.

Child welfare funds may be used to provide services to members of the child's family when the services will benefit the child (e.g., family counseling services).
Contracted (Non-Medicaid) Provider: An individual or entity that does not have a provider agreement with NMAP but has a contract with the Department to provide services covered by child welfare funds.

Drug and Chemical Diagnosis: An identified drug or chemical dependent condition as determined by a certified drug and alcohol counselor who has a contract with the Department of Social Services.

Educational Assessment: The summary of a child's educational needs as determined by -

1. The local school district;
2. The Area Educational Service Unit; or
3. The Nebraska Diagnostic and Resource Center, Cozad.

Family Assessment: An assessment of the family's level of functioning, while considering the child's physical, emotional, and social needs, and the family's ability to meet those needs.

Medicaid Provider: Any individual or entity which furnishes Medicaid services under an approved provider agreement with the Nebraska Medical Assistance Program (NMAP).

Mental Health Review Team (MHRT): A team consisting of representatives of the Medical Services, Human Services, Client Services Delivery, and Legal Divisions with expertise in psychiatric care who will consult with local workers on use of inpatient services for mental health, chemical dependency, eating disorders, or behavioral treatment. The team will approve/disapprove inpatient services based on information supplied by the worker, who is part of the team.

Psychiatric Assessment: An evaluation provided by a psychiatrist using testing and evaluation which can be expected to contribute to a psychiatric diagnosis and plan of care.

Psychiatric Second Opinion: An evaluation provided by a psychiatrist other than the original psychiatrist as deemed necessary by the Department.

Psychological Assessment: An evaluation provided by a licensed and certified clinical psychologist using testing and evaluation which can be expected to contribute to a psychiatric diagnosis and plan of care.
**State Ward Medical Unit:** A unit in the Medical Services Division which processes claims for services covered by child welfare funds under this chapter.

**Third Party Liability:** Any source from which payment for a service could be made before being paid by NMAP or child welfare funds. This may include private insurance, other available benefits, parents (either voluntarily or by court order), or the ward herself/himself from personal assets or earnings.

**41-001.05 Summary of Forms:** The following forms are addressed in this chapter. Examples and instructions for these forms are contained in the appendix.

<table>
<thead>
<tr>
<th>Form #</th>
<th>Form Title</th>
<th>Appendix Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CWI-10</td>
<td></td>
<td>471-000--___</td>
</tr>
<tr>
<td>DA-100</td>
<td>Application for Assistance</td>
<td>471-000-1</td>
</tr>
<tr>
<td>EPSDT-3</td>
<td>EPSDT Follow-Up</td>
<td>471-000-39</td>
</tr>
<tr>
<td>EPSDT-3FC</td>
<td>EPSDT Request and Treatment</td>
<td>471-000-___</td>
</tr>
<tr>
<td>EPSDT-4FC</td>
<td>EPSDT Treatment Follow-Up</td>
<td>471-000-___</td>
</tr>
<tr>
<td>HCFA-1500</td>
<td>Health Insurance Claim Form</td>
<td>471-000-52 through 471-000-65</td>
</tr>
<tr>
<td>MC-5</td>
<td>Periodic Screening Report and Claim Statement</td>
<td>471-000-83</td>
</tr>
<tr>
<td>MC-13</td>
<td>Dentist's Pre-Treatment Plan and Service Statement</td>
<td>471-000-88</td>
</tr>
<tr>
<td>MC-83</td>
<td>Psychiatric Acute Care Report</td>
<td>471-000-96</td>
</tr>
<tr>
<td>PDS-110</td>
<td>Income Maintenance Client Data</td>
<td>471-000-___</td>
</tr>
</tbody>
</table>
41-002 Billing and Payment

41-002.01 Plan for Payment: The worker shall use the following priorities to determine a plan for payment of services:

1. A provider who is paid through the parents’ insurance or by the parents (whether at full cost or reduced cost), or a no-cost provider;
2. A Medicaid provider, when the client is Medicaid-eligible and the service is covered by Medicaid;
3. A Department contractor; and
4. Another provider of service when none of the above are available or able to reimburse.

Payment of services in item 4 must be at or below Medicaid rates. If there is no Medicaid rate or Medicaid-comparable rate (e.g., chemical dependency treatment), the Medical Services Division and the Human Services Division shall jointly establish the rate. Information regarding the establishment of a rate may be requested through the Medical Services Division.

41-002.01A Identification of Need for Contracted (Non-Medicaid) Provider: When the placement worker identifies a medical or mental health need which cannot be met through a Medicaid source, the worker shall:

1. Document the need;
2. Gather all medical history which supports the medical or mental health need;
3. Develop an initial plan for services with the provider;
4. Obtain the prior approval of Medical Services staff in conjunction with Human Services staff;
5. Obtain approval from the MHRT for inpatient services for mental health, chemical dependency, eating disorders or behavioral treatment; and
6. File a copy of the approved plan in the service file and forward a copy to the State Ward Medical Unit.

(Also see 474 NAC 4-009.32C1.)

41-002.01B Use of Medicaid/Non-Medicaid Providers: The worker shall explain to the foster parent(s) that a non-Medicaid provider may be used only with approval (prior to provision of the service) of Medical Services staff in conjunction with Human Services staff. Use of a non-Medicaid provider may be approved only if there is no Medicaid provider available to provide the particular services and/or to allow the physician caring for the child at the time of initial placement to continue to provide services to the child.
41-002.01C Services Not Covered by Medicaid: The physician or the worker shall send all requests for services not covered by Medicaid (e.g., plastic surgery, scar or tattoo removal, breast reduction, or nasal reconstruction) to the Central Office, Medical Services Division to the state ward program specialist. The request must include a physician's statement which must include the following:

1. History of condition/illness;
2. Physical findings and other signs and symptoms, including appropriate laboratory data;
3. Recommended service/procedure; and
4. Expected outcome.

Risks and benefits will be weighed.

The Medical Services Division in consultation with the Medical Director shall make a decision on each request in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and the State Ward Medical Unit.

If the request is denied, the worker may provide additional information to the Human Services and Medical Services Divisions for review and reconsideration.

41-002.02 Billing Procedures: Medical billings for children must be submitted on Medicaid forms with appropriate documentation as required in 471 NAC.

41-002.02A Contracted (Non-Medicaid) Providers: All contracted (non-Medicaid) providers shall submit billings to the State Ward Medical Unit. The local office shall provide the non-Medicaid provider with proper forms (or information on how to obtain forms), procedure codes, and billing procedures.

41-002.02B Medicaid Providers: For Medicaid eligible wards, Medicaid providers shall first bill NMAP. If a claim is denied, NMAP sends it to the State Ward Medical Unit. If a denied claim is inadvertently returned to the provider, the provider shall resubmit the claim along with the Medicaid denial to the State Ward Medical Unit for review and processing.

41-002.02C Inquiries: The worker may direct inquiries regarding rates, procedure codes, and dollar limitations to the appropriate Medical Services Division program specialist for the specific service being provided.

41-002.03 Payment by Foster Parent: Foster parents should not pay a medical provider for services rendered to a Department ward. The foster parent will not be reimbursed unless there has been written prior authorization signed by the worker and service supervisor, except in emergency situations where the foster parent is required to pay for a medical expense. The worker shall send a copy of any written authorization to the State Ward Medical Unit.
41-003 Family and Child Welfare Mental Health Services: Also see 471 NAC 20-000 ff. regarding Medicaid-covered mental health services and 474 NAC 4-003 ff. regarding mental health services.

41-003.01 Funding: The worker shall use the following priorities to establish a plan for payment for mental health services:

1. A provider paid through parents’ insurance, by parents (whether at full cost or reduced cost), or a no-cost provider;
2. Medicaid provider when the client is Medicaid-eligible and the service is reimbursable through Medicaid;
3. Department contractor;
4. Another provider of service when none of the above are available or able to reimburse.

Payment of services in item 4 must be at or below Medicaid rates. If there is no Medicaid or Medicaid-comparable rate (e.g., chemical dependency treatment), the Medical Services and Human Services Divisions shall establish the rate jointly. A decision will be made within 30 days of the receipt of complete information. Information regarding the establishment of a rate may be requested through the Medical Services Division.

Note: Under provisions of the juvenile code, the Department does not pay for evaluations that are ordered by the juvenile courts to be completed at the Youth Development Center at Geneva and Kearney.

41-003.02 Providers: If resources outside the Nebraska Department of Social Services are used to obtain a psychological or psychiatric, mental health, chemical dependency, evaluation and/or treatment, the resource(s) must be:

1. A state licensed community mental health center which has a provider agreement, as stated in 471 NAC 20-004.01A;
2. A master or doctoral level clinical psychologist;
3. A psychiatrist;
4. A mental health facility of the Nebraska Department of Public Institutions;
5. A licensed or formally approved hospital which provides psychiatric services (See service limitations 471 NAC 20-006.01);
6. An individual with a masters in social work or clinical or counseling psychology; or
7. A certified drug and alcohol counselor for chemical dependency evaluations only.

41-003.03 Evaluations: The worker shall follow 471 NAC 41-003.01 and 41-003.02 in obtaining evaluations of the child. Evaluations must be conducted in the least restrictive or intrusive manner.
41-003.03A Inpatient Evaluations 15 Days or Less: The worker shall obtain approval of the District Administrator or his/her designee before a child receives -

1. An inpatient psychiatric evaluation;
2. An inpatient chemical dependency evaluation (Note: an inpatient stay of up to two days for detoxification as covered by Medicaid is allowed);
3. An inpatient evaluation for eating disorders; or
4. An inpatient evaluation for behavior problems.

Before approving these evaluations, the District Administrator (or his/her designee) shall review documentation of the child's specific need for evaluation in an inpatient setting, including any information on attempts to secure the evaluation on an outpatient basis. Inpatient evaluations are limited to 15 calendar days.

41-003.03B Inpatient Evaluations Longer Than 15 Days: An inpatient evaluation beyond 15 days in length may be provided to a child only with approval of the appropriate District Administrator (or his/her designee) and the Mental Health Review Team. If the District Administrator approves the request to extend the evaluation, s/he shall submit documentation which justifies the medical necessity of continued inpatient evaluation to the MHRT. This documentation must be submitted as soon as possible and no later than the 14th day of the original 15-day evaluation period. The MHRT will be convened and shall respond within 24 hours or by the end of the 15th day. Documentation must include -

1. Name of district and local office, names and phone numbers of worker and supervisor;
2. Name and Social Security number of the child;
3. Name and phone number of the referring psychiatrist or physician;
4. Name of the facility;
5. Date and purpose of admission;
6. Presenting problem;
7. Reason for selecting inpatient (rather than outpatient) setting;
8. Discharge plan, including date of planned discharged; and
9. Copies of evaluations, progress reports, recommendations, etc.
41-003.04 Outpatient Mental Health Services: The Department covers outpatient mental health services to provide services in the least restrictive setting and to prevent unnecessary inpatient residential treatment. NMAP limits payment for outpatient mental health services to payment for medically necessary services for a primary acute psychiatric diagnosis (see 471 NAC 20-004). Child welfare funds may be used to pay for outpatient services to Department wards and their families if NMAP does not cover those particular services or denies payment for the services based on lack of medical necessity. Providers shall submit documentation as required in 471 NAC 20-004.04 and 20-004.05 for all outpatient services.

If the assessment of the child's and family's needs indicates the need for ongoing counseling services, the worker shall develop a counseling plan with the participation of the family. The purpose of the plan is to clarify expectations for the family, worker, and service provider and to provide the supervisor with information necessary for approval of the plan and, when appropriate, funding. It must be shared with the family.

The counseling plan must be attached to the case plan and must include the following:

1. The reasons counseling services are recommended (including problems or issues to be worked on in counseling);
2. The goals identified;
3. The type of counseling services;
4. The provider;
5. The estimated length of counseling; and
6. If child welfare funds are requested:
   a. Alternative payment resources explored; and
   b. Estimated cost of counseling.

After approval of the counseling plan by the worker and family, the worker shall send one copy of the plan/authorization to the provider and one to the Medical Services Division, Central Office and keep a copy in the case file.

The worker shall request that the provider submit a progress report at least every three months or as specified by contract. Form MC-83 may be used for this report. The worker shall review the need for continued counseling services with his/her supervisor after three months of ongoing treatment, determine progress made and need for continued services or modification in the case plan, and document the need in the case file. If services are continued, the worker and supervisor shall review and document the need for continued services at least every three months thereafter, again utilizing form MC-83. With participation of the family, the worker shall update the treatment plan at least every three months.
Supervisory review and approval are required for continuous counseling beyond an initial six-month period and every three months thereafter.

The worker shall forward a copy of all approvals (worker's or supervisor's as appropriate) to the Central Office, Medical Services Division. Approvals must be received by the Medical Services Division in order for payments to be processed.

Also see 474 NAC 4-003.02C.

41-003.05 Inpatient Psychiatric Services: The Department covers inpatient psychiatric services to provide treatment for a Department ward who is unable to benefit from less restrictive treatment. Child welfare funds may be used to pay for inpatient treatment for Department wards if NMAP does not cover or denies a particular service for lack of medical necessity and if the services were approved by MHRT or special approval. The worker shall apply 471 NAC 41-003.01 and 41-003.02 to obtain these services. For Department wards in Institutions for Mental Disease, see 471 NAC 20-007 ff.

Inpatient treatment may be provided to a ward only with advance approval of the appropriate District Administrator (or his/her designee) and the Mental Health Review Team. After the District Administrator approves a request, s/he shall submit a written request for inpatient treatment, including the following documentation, to the MHRT:

1. Name of district and local office, names and phone numbers of worker and supervisor;
2. Name and Social Security number of the ward;
3. Name and phone number of the referring psychiatrist or physician;
4. Name of the facility;
5. Date and purpose of admission;
6. Presenting problem;
7. Reason for selecting inpatient (rather than outpatient) setting;
8. Discharge plan, including date of planned discharge; and
9. Copies of evaluations, progress reports, recommendations, etc.
The MHRT shall meet and provide a response within 24 hours, or by the end of the 15th day when the District Administrator has previously approved inpatient evaluation.

The MHRT has the authority to -

1. Approve inpatient treatment for the period of time that is medically necessary;
2. Approve additional days of inpatient treatment (to approve additional days, the team must receive a request from the District Administrator and conduct a review of evaluations, recommendations, progress reports, etc.);
3. Conduct follow-up reviews of a case while the ward is receiving inpatient treatment; and
4. Conduct on-site interviews as part of the assessment and decision-making process.

Decisions made by the team are final. If inpatient treatment is not approved for a Department ward who is in the facility, the ward must be moved within 24 hours. No exceptions to this requirement will be allowed.

41-003.05A Out-of-State Inpatient Psychiatric Treatment: The worker shall request approval for out-of-state inpatient psychiatric treatment according to the process in 474 NAC 4-009.16 ff.

41-003.06 Chemical Dependency Treatment

41-003.06A Outpatient Chemical Dependency Counseling: The Department covers outpatient chemical dependency counseling to provide treatment in the least restrictive setting which permits the child to continue to receive public education and reside in the community. Whenever possible, the family must be included in the treatment alternatives. Child welfare funds may be used for payment of outpatient chemical dependency counseling as contracted by the Department.

If a placement worker determines that a Department ward may have a chemical dependency problem, the worker shall arrange an evaluation by a certified drug-alcohol counselor. Treatment for a family member may be made from Family Support funds when the goal is reunification (see 474 NAC 4-009.32B8c(1)). If treatment is indicated, the first alternative must be outpatient counseling with a qualified professional.
If the assessment by a certified drug-alcohol professional identifies the need for treatment, the worker shall present a plan for treatment to the service supervisor for approval. The plan for treatment must include -

1. Reports from all prior assessments and treatments;
2. The resource that will provide the services;
3. The estimated cost of treatment;
4. The estimated length of treatment; and
5. A listing of special requirements from the provider (i.e., progress reports, diagnosis, prognosis, possible court appearances, and collateral consultations).

If the supervisor approves the plan for treatment, s/he shall submit the plan to the District Administrator for a decision. The worker forwards one copy of the authorization to the provider, one copy to the Medical Services Division, and files a copy in the service file.

Payment of services in the last category must be at or below Medicaid rates. If there is no Medicaid or Medicaid-comparable rate (e.g., chemical dependency treatment), the rate shall be established jointly by the Medical Services and Human Services Divisions. A decision will be made within 30 days of the receipt of complete information. Information regarding the establishment of a rate may be requested through the State Ward Medical Unit.

The length of treatment is determined by the youth's progress and a joint decision made by the caseworker with input from the counselor and approval of the supervisor. The caseworker shall monitor the treatment case plan to ensure that the treatment is being followed and continues to be appropriate.

41-003.06B Inpatient Chemical Dependency Treatment: The Department covers inpatient chemical dependency treatment to provide intensive chemical dependency treatment that cannot be provided on an outpatient basis. Before inpatient chemical dependency treatment is authorized, the placement worker shall explore all appropriate outpatient resources and document in the case record. Inpatient chemical dependency treatment must be approved by the MHRT as described in 471 NAC 41-003.05.

41-003.06C Out-of-State Treatment: The worker shall request approval for out-of-state chemical dependency treatment according to the process in 474 NAC 4-009.16 ff.
41-004 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): The Early and Periodic Screening, Diagnosis, and Treatment Program was established by Title XIX of the Social Security Act. It is funded by a combination of state and federal money.

Section 43-1311, Reissue Revised Statutes of Nebraska, 1943 requires that a child have a medical examination and any necessary further diagnosis and evaluation within two weeks of removal from his/her home.

Section 68-1020, R.S. Supp., 1984 authorizes payment from state funds for EPSDT services for Department wards who are not Medicaid-eligible.

41-004.01 Purpose and Scope: EPSDT is a service available to all individuals age 20 and younger eligible for medical assistance. The purpose of EPSDT is to provide -

1. Early detection of illness or defects through a screening examination;
2. Follow-up of the condition detected during a screening; and
3. Continuity of care. It is intended to encourage and ensure that treatment is available and received by those eligible and in need of treatment.

Child welfare funding may be used to pay for EPSDT for Department wards if NMAP does not cover or denies the claim for a particular service or if the child is not Medicaid-eligible.

41-004.02 Benefits of Preventive Health Care: Preventive health care provides the following benefits for the child:

1. Early detection and treatment of health problems to prevent permanent impairment and to increase the chance of successful treatment;
2. Protection from certain preventable diseases by immunization for children at an early age;
3. Maintenance of good health and assurance of normal development through periodic check-ups; and
4. Savings of future medical costs.
41-004.03 Worker Responsibilities (Also see 474 NAC 9-009.32A.)

41-004.03A Informing the Child and Parents: A child must have a medical evaluation and any necessary further diagnosis and evaluation within two weeks of removal from his/her home. The worker who has responsibility for the initial placement or the ongoing case manager shall explain the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program to the child or the unit receiving the cash assistance (e.g., foster parent, facility administration) within ten days of placement. The explanation must include a review of the EPSDT pamphlet. The worker shall ensure that there is an opportunity to ask questions about EPSDT.

The worker responsible for placement or the ongoing case manager shall ensure that the State Ward Medical Unit is contacted by the foster parent or contacts the State Ward Medical Unit to provide the name and address of the screening physician. The State Ward Medical Unit shall send Forms MC-5 and EPSDT-3FC to the provider. The provider shall return the completed forms to the State Ward Medical Unit. The State Ward Medical Unit shall send a copy to the worker for the case record. The worker shall follow-up to ensure that the child's medical needs are properly treated.

In addition, for Department wards, the IM worker shall send to the child and/or family or facility notification when the child is due for medical and dental exams according to the periodicity schedule or annually after the initial informing.

The worker shall adapt these informing procedures to meet the needs of persons with handicapping conditions, e.g., blindness, deafness, etc. Translated materials or an interpreter are appropriate for informing individuals who cannot understand the English language.

For those individuals accepting EPSDT and requesting services, the case manager shall provide assistance in arranging transportation, locating a doctor or a dentist, or scheduling appointments.

Also see 474 NAC 4-009.32B2.

41-004.03B Assisting With Appointments and Transportation: The worker shall offer assistance or referral in scheduling appointments and providing transportation for the screening exam and treatment services and provide these if requested and necessary. To ensure timely delivery of services, the worker shall have available, upon request, the names and locations of Medicaid providers (physicians, clinics, and dentists) and Title V Medically Handicapped Children’s Program providers.
The worker responsible for placement or the ongoing case manager shall ensure that the State Ward Medical Unit is contacted by the foster parent or contacts the State Ward Medical Unit to provide the provider(s)' name. The State Ward Medical Unit shall send Form MC-5 and/or Form MC-13, as appropriate, to the appropriate provider.

The screening exams are to be performed within 120 days of the initial and periodic request. The case manager or designated worker shall establish a method of tracking whether the exams were performed, such as contacting the foster parent or facility, contacting the State Ward Medical Unit, or checking computerized information (e.g., Medicaid claim history on Job 045, or EPSDT printouts). If the screening is overdue, the worker shall make at least one contact in an effort to provide timely services. One followup contact is considered a good faith effort to provide timely delivery of services.

As follow-up, the case manager or designated worker shall inform the child or family/facility of the need for further diagnosis or treatment services and assure that transportation and appointment scheduling is provided if requested and necessary, to enable the child to receive timely diagnosis and treatment as stated on the child health record or on Form MC-5 (EPSDT) or MC-13 (dental). This can be accomplished by Form EPSDT-4FC or a similar contact. The case manager or designated worker shall establish a method of tracking to assure the timely provision of services. The case manager or designated worker shall make at least one contact in an effort to provide timely services. One follow-up contact is considered a good faith effort to assure initiation of treatment.

For children who are not wards of the Department, see 471 NAC 18-005 ff and 468 NAC 5-000 ff.

41-004.03C Documenting Contact and Assistance: Written documentation in the ward's IM file of the child is necessary to show -

1. That the child and foster parent or facility administration have been informed. Check the agency record at the time of the initial or subsequent contact that the child and family or facility have been informed of the EPSDT program in writing and by verbal explanation. This is accomplished by the completion of Form CWI-10 and by entry on Form PDS-110 (see 474 NAC 4-009.32A1). The informing date is the initial custody date;
2. That the supportive services of appointment scheduling and transportation assistance have been offered to the child and foster parent and are provided if requested. This is accomplished by completing Form CWI-10 and by an entry on Form PDS-110 (see 474 NAC 4-009.32A1).

3. The State Ward Medical Unit will send Form MC-5 for Department wards to the screening physician. Upon receipt of Form MC-5 from the screening physician, the State Ward Medical Unit sends a copy to the IM foster care worker to record and forward to the worker.

After the Department ward has received a screening, the provider shall send Form MC-5 directly to the State Ward Medical Unit, for claims processing and payment. The State Ward Medical Unit shall send a copy to the appropriate IM foster care worker in the local or district office. The IM foster care worker enters data directly to show that the EPSDT service has been completed. The IM foster care worker shall copy Form MC-5 and send the copy to the appropriate placement worker to file in the service file.

For children who are not wards of the Department, see 471 NAC 18-005 ff.

The State Ward Medical Unit copy of Form MC-5 is the record of the completed medical screening, and the State Ward Medical Unit copy of Form MC-13 is the record of completed dental screening for children age three and older. The case manager shall document the need for the initiation of treatment in the child's health record and send a reminder of the need for treatment, if indicated, by using a reminder letter, EPSDT-4FC, or similar contact.

41-004.04 Coordination With Other Requirements for Physical Examinations: The worker and the State Ward Medical Unit shall make efforts to coordinate screening with programs such as required physicals in the public schools, Head Start, placement in a group home, and other programs which require examinations. Physicians shall use Form MC-5 for screening to avoid duplication of claims.

Under state law, a child must receive a medical examination within two weeks of removal from his/her home. Form MC-5 is used by physicians to avoid duplication of claims for this examination.

The EPSDT exam may be used to meet the required examination after a child's removal from his/her home.
41-004.05  Referral for Services Not Covered by Medical Assistance: The worker shall provide referral assistance for treatment not covered by NMAP but found to be needed as a result of conditions disclosed during the screening exam. This may include referral to the Title V Medically Handicapped Children’s Program or services provided for a sliding fee or at no cost. This referral assistance must include giving the child and/or family the names, addresses, and the telephone numbers of providers who have expressed a willingness to provide services not covered by NMAP at little or no expense to the client. Workers may contact the EPSDT coordinator in the Medical Services Division for referral resources.

41-004.06  Payment Procedure: For payment procedure, see 471 NAC 18-005.06.
41-005 Dental Treatment: All dental procedures paid for with child welfare funds are governed by the guidelines of NMAP, 471 NAC 6-000 ff. Child welfare funding may be used only if the claim is denied by NMAP or the services are not covered by NMAP. NMAP requires authorization of all dental treatment that exceeds a total cost of $145 prior to the provision of the treatment. The $145 prior authorization amount does not include fees for exams, radiograms, prophylaxis, and topical application of fluoride (see 471 NAC 6-005 and 6-006).

To request approval for a proposed dental program, the dentist shall submit the completed Form MC-13 with all necessary mounted radiograms to the Medical Services Division for the dental consultant's review and approval as required in 471 NAC 6-005.01.

If need for emergency treatment arises and the child or youth must be seen before authorization can be obtained from the dental program specialist, the caseworker is authorized to secure emergency treatment. The worker shall inform the dentist that only the emergency is to be treated. The caseworker shall contact the Medical Services Division dental program specialist immediately for authorization for payment of the emergency.

If NMAP does not cover or denies a treatment plan (e.g., orthodontic treatment, cosmetic procedures) and the worker's assessment of the youth's needs reflects a need for a particular treatment, the worker or the dentist shall send a request to the Central Office Medical Services Division to the attention of the state ward medical program specialist. The request must contain:

1. A complete explanation of what needs to be done (treatment plan, length and cost of treatment);
2. Reasons for the procedure - cosmetic, psychological, physical, etc.;
3. Supporting information from an orthodontist, dentist, psychiatrist, or M.D.; and
4. Follow-up treatment plan, cost and length of treatment, and the estimated date of completion.

A decision to approve or disapprove this care is made by the Medical Director in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and to the State Ward Medical Unit.

If the initial request is denied, the worker may send additional information to the Human Services and Medical Services Divisions for review and reconsideration.
41-006 Visual Care Services: All visual care services paid for with child welfare funds are governed by the guidelines of NMAP, 471 NAC 24-000 ff. Child welfare funds may be used to pay for visual care services only if the claim is denied by NMAP because of lack of medical necessity, the service is not covered by NMAP, or the provider is a non-Medicaid provider. To request approval to use child welfare funds to purchase other special provisions that are medically necessary when NMAP has denied the special provisions, the worker or the physician shall send a request to the Central Office Medical Services Division to the attention of the state ward medical program specialist. The request must include a physician’s statement that contains the following:

1. History of the condition/illness;
2. Physical findings and other signs and symptoms, including pertinent laboratory data;
3. Recommend service/procedure; and
4. Expected outcome.

A decision to approve or disapprove the request is made by the Medical Director in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and to the State Ward Medical Unit.

If the initial request is denied, the worker may send additional information to the Human Services and Medical Services Divisions for review and reconsideration.

There is no provision available for a child to supplement or pay a portion of a Medicaid-covered visual care service. If a youth desires contact lenses, more expensive frames than Medicaid will allow, tinted lenses, prescription sunglasses, or any other special provisions not covered by Medicaid, these may be paid out of the child's own funds or by the child's parents if they are willing to do so.
41-007 Durable Medical Equipment and Medical Supplies: All child welfare fund purchases or rental of any durable medical equipment and medical supplies must be in accordance with regulations of NMAP, 471 NAC 7-000 ff. Child welfare funds may be used for the purchase or rental of durable medical equipment and/or medical supplies if the service is denied because of lack of medical necessity or not covered by NMAP. To request approval to use child welfare funds for the purchase or rental of durable medical equipment and/or medical supplies, the worker shall send a request to the Central Office Medical Services Division state ward program specialist. The request must include a physician’s statement that contains the following:

1. History of the condition/illness;
2. Physical findings and other signs and symptoms, including pertinent laboratory data;
3. Recommend service/procedure; and
4. Expected outcome.

A decision to approve or disapprove the request is made by the Medical Director in consultation with Human Services staff. A decision will be made within 30 days of the receipt of complete information. A copy of the decision is sent to the child's worker and to the State Ward Medical Unit.

If the initial request is denied, the worker may send additional information to the Human Services and Medical Services Divisions for review and reconsideration.

The approval must contain -

1. A prescription from a licensed practitioner which describes the condition necessitating the medical need for the equipment and/or services;
2. The rental and purchase price of the item;
3. Name and address of the provider; and
4. Length of time the item is needed.
CHAPTER 42-000  FREESTANDING BIRTH CENTERS

42-001  STANDARDS FOR PARTICIPATION: Medicaid covers facility services provided by non-hospital freestanding birth centers. To participate in Medicaid, a freestanding birth center must:

1. Be licensed by the Department of Health and Human Services, Division of Public Health, as a facility providing labor and delivery services and not licensed as another type of health care facility and maintain standards of care required by the Department of Health and Human Services, Division of Public Health for licensure.
2. The center must have a written agreement for emergency care with a hospital that provides obstetrical services or each medical practitioner practicing at the facility must have admitting privileges at a transferring hospital.
3. Admissions to the facility must be restricted to uncomplicated (low-risk) patients. Planned caesarean section procedures are prohibited.
4. Each mother and newborn must be discharged within 24 hours after admission, in a condition which will allow or not endanger the well-being of either. If the condition of mother or newborn does not allow discharge within 24 hours, then transfer to a hospital must occur.
5. The birth center must be enrolled and approved by the Department or its designee for participation in Medicaid.
6. The birth attendant must be licensed at the time and place the services are provided and must be enrolled and approved by the Department or its designee for participation in Medicaid.

42-001.01  Definition of a Freestanding Birth Center: A Freestanding Birth Center means a health facility:

1. That is not a hospital;
2. Where childbirth is planned to occur away from the pregnant woman’s residence;
3. That is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services; and
4. That complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

42-001.02  Definition of a Birth Attendant: A birth attendant means an individual who is licensed by the State to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law.

42-001.03  Provider Agreement: The provider must complete and sign Form MC-19, “Medical Assistance Provider Agreement,” (see 471-000-90) and submit it to the Department to be approved for provider enrollment.
42-002 COVERED BIRTH CENTER FACILITY SERVICES: Coverage of birth center facility services is limited to certain birth services provided by the center and determined by the birth attendant to be necessary for the care of the mother and live newborn child following the mother’s normal, uncomplicated pregnancy. Reimbursable services are limited to facility services provided during the labor and delivery. These items and services are those that would otherwise be covered by Medicaid if provided on an inpatient or outpatient basis in a hospital in connection with the services provided by the center. Birth center facility services furnished prior to or after the above described period are not considered birth center facility services and are not covered or reimbursed.

Services provided by the birth attendant are not considered to be birth center facility services. The fee for the birth center facility services does not include payment for medical or other health services such as the birth attendant’s services.

42-003 (RESERVED)

42-004 BILLING REQUIREMENTS

42-004.01 Required Forms: When billing Medicaid, the Birth Center must submit using the paper Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49).

42-004.02 Procedure Codes: To bill the Birth Center facility fee, the Birth Center must use the appropriate HCPCS/CPT procedure codes. Birth Centers may only be reimbursed by Medicaid for their facility labor and delivery services. Birth attendants’ services or other services not directly related to the labor and delivery services, along with prenatal or family planning services in the birth center setting must be submitted on separate claims. Claims for non-facility services need to be submitted utilizing the appropriate HCPCS/CPT procedure codes on the paper Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

42-005 PAYMENT FOR BIRTH CENTER SERVICES

42-005.01 Fee for Birth Center Facility Services: Birth Centers may only be reimbursed for facility labor and delivery services. The department will establish maximum reimbursement fees for birth center services based upon the average of published rates from the State Medicaid Programs of other states that have published rates for such services. Rates may also be adjusted in accordance with legislative appropriations or budget directives from the Nebraska Legislature, which may result in Medicaid payment rate increases or decreases.

42-005.02 Payment for Services Not Included in the Birth Center Facility Services Fee: The fee for facility services does not include payment for birth attendants’ services or other services not directly related to the labor and delivery services.