NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

May 29, 2026
10:00 A.M. Central Time
Nebraska State Office Building – Lower Level
Meadowlark Conference Room
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on the proposed amendments to the following regulations:

Title 471 NAC 10 – *Hospital Services*

The proposed changes update the regulations' scope and authority; update definitions; update prior authorization requirements for sleep studies; add service requirements for long-term acute care hospital services; set mammography screening and diagnostic requirements; update billing and payment for hospital services requirements; add beneficiary medical records requirements; update section headings; clarify language; update terminology and acronyms; remove unnecessary and duplicative language; correct typographical and punctuation errors; and renumbering the regulatory chapter.

Title 471 NAC 46 – *Rates for Hospital Services*

The proposed changes update the regulations' scope and authority; update definitions; add payment for hospital-sponsored psychiatric residential treatment facilities requirements; set requirements on payment for long-term acute care hospital services; establish requirements on payment for outpatient mental health and substance use disorder services that are provided in a hospital setting; incorporate new Peer Group numbering; establish requirements for payment for non-acute admin days; set requirements for payment methodology for swing bed days; add requirements for hospital providers participating in Nebraska Medicaid that do not comply with the Hospital Quality Assurance and Access Assessment Act; update section headings; clarify language; update terminology and acronyms; remove unnecessary language; correct typographical and punctuation errors; and renumber the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7) and § 68-901 et seq.

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

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417.

The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Jeremy Brunssen
Chapters: 10 and 46	Date prepared: 4/13/2026
Subject: Hospital Services and Rates For Hospital Services	Telephone: 402-540-0380

Type of Fiscal Impact:

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

Provide an Estimated Cost & Description of Impact:

State Agency: There are offsetting fiscal impacts to the agency.

Hospital Quality Assurance and Access Assessment Act, (Neb. Rev. Stat. § 68-1009, LB227 (2023)): There is an estimated increase in federal expenditures associated with these changes of approximately $969 million annually. There is not an estimated increase in state expenditures for these changes as the non-federal share of the payments is hospital assessments, which are primarily used as the source for matching the additional federal financial participation for payments to providers. The annual assessment amount expected to be collected as revenue and then used to make direct payments to hospitals is approximately $475 million. In addition, small portions of the assessment collected under this assessment are allowed to be used by the Nebraska Medicaid as detailed in Neb. Rev. Stat. § 68-2103, (LB1087 (2024)). This includes revenue for state budget program 348 not to exceed $17.5 million per year; revenue for state budget program 033 not to exceed $15 million per year; and revenue to the Nebraska Center for Nursing Board not to exceed $2.5 million per year.

Nebraska Medicaid will require one additional full-time employee as part of implementing this new assessment program. This position will be a Reimbursement Analyst with a new cost to the state of approximately $72,791.

Hospital inpatient nursing facility level of care (LOC) (titled “Non-Acute Admin Days” in 471 NAC 46) – There is an estimated increase in expenditures annually of approximately $3,081,341 in total funds. Appropriations were provided as part of the passage of Neb. Rev. Stat. § 68-1009, (LB227 (2023)).

Long-Term Acute Care Hospitals (LTACH) - There is no estimated fiscal impact on these proposed changes as Nebraska Medicaid already reimburses long-term acute care hospitals (LTACH) under other current hospital peer group payment methodologies and these changes transition the hospitals to a new provider type and specialty.

Rural Emergency Hospitals – There is no estimated fiscal impact for these proposed changes as Nebraska Medicaid already reimburses critical access hospitals (CAH) and is proposing reimbursing this new provider type and specialty consistent with historical reimbursement.

Political Subdivision: N/A.

Regulated Public: There is an increase in total revenue for hospitals as a result of these changes. Specifically, the Hospital Quality Assurance and Access Assessment Act, Neb. Rev. Stat. § 68-1009, (LB227 2023), will result in the Nebraska Medicaid program drawing down additional federal financial participation that will increase payments made to hospitals in Nebraska. The increased payments and revenue of more than $900 million annually to hospitals is from federal funds obtained as a result of matching assessment revenue collected by Nebraska Medicaid from hospitals and paid back out with federal financial participation. Additionally, the hospital inpatient nursing facility level of care (LOC) changes result in an increase in payment from the Nebraska Medicaid program to hospitals, estimated to be approximately $3,081,341 in total funds annually, eligible for federal financial participation at Nebraska’s federal medical assistance percentage rate.

If indeterminable, explain why: N/A.

PROPOSED REGULATION
POLICY PRE-REVIEW CHECKLIST

Agency: DHHS – Division of Medicaid and Long-Term Care
Title, Chapter of Regulation: Title 471 Chapters 10 and 46
Subject: Hospital Services and Rates for Hospital Services
Prepared by: Drew Preston
Telephone: 531-739-7017

A. Policy Changes and Impacts.

1. What does the regulation do and whom does it impact? Provide a brief description of the proposed rule or regulation and its impacts on state agencies, political subdivisions, and regulated persons or entities.

   Title 471 Chapters 10 and 46 govern Nebraska Medicaid's coverage of hospital and nursing facility services. Title 471 NAC 10 governs Nebraska Medicaid's service requirements around inpatient hospital services, while Title 471 NAC 46 governs how Nebraska Medicaid reimburses hospitals for the services they provide to Nebraska Medicaid beneficiaries. These regulations impact a wide array of stakeholders, from Nebraska Medicaid beneficiaries who may require hospital services, to providers of hospital-based services (nursing facilities and hospitals that accept Nebraska Medicaid beneficiaries). Nebraska Medicaid payment rates to hospitals are important to the community at large in areas with Nebraska Medicaid-enrolled hospitals.

   No other entities or political subdivisions will be impacted.

2. Describe changes being proposed to current policy and briefly provide rationale.

   The changes being proposed to these chapters add new hospital provider specialty types that may enroll with Nebraska Medicaid, which will improve access options for beneficiaries. These new enrollment specialty types include rural emergency hospital and long-term acute care hospital (LTACH). Other changes clarify service requirements and levels of care (LOC), specifically the hospital inpatient nursing facility level of care (LOC). Rate-setting methods have been revised to account for these new provider types. New language is being added to the proposed changes to account for the new Hospital Quality Assurance and Access Assessment Act, Nebraska Revised Statute (Neb. Rev. Stat.) § 68-2103 (LB1087, 2024).

   The main changes being made to 471 NAC 10 include:
   - Section 001: Updated the regulations' scope and authority.
   - Section 002:

- Added new definitions: Ambulatory Room and Board, Ancillary Services, Extended Stay, Swing Bed, Swing Bed Facility, and Transplant Diagnosis-Related Group, Long-Term Acute Care Hospital (LTACH), Clinical Trials, and Rural Emergency Hospital.
- Made minor language adjustments to clarify existing definitions, updated terminology and acronyms, renumbered and reorganized the section, corrected typographical and punctuation errors, and removed unnecessary language.

- Section 003:
  - Removed an unnecessary section regarding durable medical equipment, removed unnecessary language, clarified language, updated terminology, corrected punctuation, and renumbered the rest of the section accordingly.
- Section 004:
  - Section 004.01: Updated prior authorization requirements for sleep studies and clarified language around the notification process for prior authorizations. Updated terminology and correct typographical errors.
  - Section 004.02(B): Clarified language.
  - Removed section 004.01(B)(i)(2).
  - Section 004.02: Updated language and prior authorization requirements around bariatric surgery. Updated terminology, removed unnecessary language, and updated section headings.
  - Section 004.03: Removed an unnecessary section on leaves of absence (004.03(B)) and added service requirements for long-term acute care hospital (LTACH) services. Removed unnecessary language, clarified language, renumbered the section accordingly, and updated terminology.
  - Section 004.04, 004.05, 004.06, and 004.07: Minor clarifying language added, removed unnecessary section headings, renumbered the sections, added missing section headings, and updated terminology.
  - Section 004.08: Removed an unnecessary section related to Computerized Tomography (CT) scans (004.08(C)). Removed unnecessary language, clarified language, renumbered the section accordingly, and updated terminology and acronyms.
  - Section 004.08(C)(i) and 004.08(C)(ii) added mammography screening and diagnostic requirements.
  - Section 004.09: updated section headings, and terminology. Removed unnecessary language.
  - Section 004.10: Removed unnecessary language, clarified language, updated section headings, removed section 004.10(B)(iii) and moved to relevant portions to section 004.10(B)(ii), and updated terminology.

- Section 004.11, 004.12, 004.13, 004.14, 004.15, and 004.16: Minor clarifying language added, updated terminology, and updated section headings, and removed unnecessary language.
- Section 004.17: Added language to clarify hospital dental services coverage and removed unnecessary language.
- Section 004.18: Removed unnecessary language, and updated terminology.

- Section 005:
  - Clarified language around hospital acquired conditions and removed an unnecessary section. Updated terminology, corrected typographical errors, removed additional unnecessary language, removed sections 005.01, 005.02, and 005.11 renumbered the section.
- Section 006:
  - Updated references to bariatric surgery and the postpartum coverage period. Updated terminology, acronyms, section headings, corrected typographical errors, clarified language, removed unnecessary language, removed sections 006.01(A), 006.01(B), 006.001(C), 006.01(D), and 006.21(B), and renumbered the section.
- Section 007:
  - Section 007.01: Removed several unnecessary sections as the requirements are duplicative of language in Title 471 NAC 46. Renumbered the section accordingly. Updated inpatient services, updated terminology and acronyms, updated section headings, and corrected typographical and punctuation errors. Clarified language around claim types that are examined for provider preventable conditions, types of providers who may participate in a utilization review committee, requirements for recertifying continued stays, billing requirements for swing beds and ancillary services and therapies, and added a requirement specifying that providers may not withhold a Nebraska Medicaid beneficiary's records on account of cost. Removed unnecessary language.
- Section 008:
  - Added missing section headings, added beneficiary medical records requirements, updated terminology, clarified language,

The main changes being made to 471 NAC 46 include:

- Section 001: Updated the regulations' scope and authority.
- Section 002:
  - Revised existing definitions of All-Patient Refined Diagnosis-Related Group, Critical Access Hospital (CAH), Low-income Utilization Rate, Medicare Cost Report, Operating Cost Payment Amount, Peer Group, and Peer Group Base Payment Amount.

    - Added new definitions for Hospital Quality Assurance and Access Assessment, Non-Acute Admin Days, Long-Term Acute Care Hospital (LTACH), Rural Emergency Hospital, Swing Bed (copied from Ch. 10), and Transplant Diagnosis Related Group.
    - Removed unnecessary language, clarified language, updated terminology and acronyms, and renumbered the section.
- Section 003:
    - Section 003: Updated section headings, added clarifying language, and updated acronyms.
    - Section 003.01: Added language to clarify existing requirements and to remove unnecessary language. Updated section headings.
    - Section 003.02: Added language to clarify existing requirements and to remove unnecessary language. Updated terminology, and removed section 003.02(B)).
    - Section 003.03: Added language to clarify the calculation of direct medical education (DME) cost: the process of calculating various cost payments and removed unnecessary language. Added language to clarify requirements around facility specific upper payment limits and removed unnecessary language on this topic. Added new language around payment for certified registered nurse anesthetist (CRNA) services and transplant diagnosis related group direct medical education payments. Updated terminology and acronyms, updated section headings, and corrected typographical and punctuation errors.
    - Section 003.03(C) removed.
- Section 004: Added clarifying language, updated terminology and acronyms, and removed unnecessary language.
- Section 005: Added clarifying language, updated terminology, and removed unnecessary language. Added a new section on payment for hospital-sponsored psychiatric residential treatment facilities.
- Section 006: Added a new section to clarify requirements around payment for in-state outpatient hospital and emergency room services. Removed Section 006.02, and renumbered the section.
- Section 007: Removed unnecessary language, updated terminology and acronyms, added clarifying language, and renumbered the section.
- Section 008: Removed unnecessary language, and added acronyms.
- Section 009: Added new section setting the requirements on payment for long-term acute care hospital (LTACH) services. Removed section 009 and subsections that are now no longer necessary.

- Section 010: Added a new section setting the requirements on payment for outpatient mental health and substance use disorder services provided in a hospital setting.
- Section 011: Minor grammatical corrections, and added acronyms. (was section 008, renumbered) Removed existing section 011.
- Section 012: Changes throughout this section made to align with the new Peer Group numbering. Minor clarifying language added, and unnecessary language removed throughout the section. Errors in subsection numbering corrected. Updated terminology and acronyms, updated section headings, and corrected punctuation.
- Section 013: Added new language to this section to incorporate the new Peer Group numbering. Largely struck the existing section (was section 010). Updated terminology and renumbered the section.
- Section 014: Added clarifying language and removed outdated language. Updated terminology and acronyms. Renumbered section, was section 011.
- Section 015: Set requirements for payment for non-acute admin days.
- Section 016: Added a new section setting out the requirements for payment methodology for swing bed days.
- Section 017: Renumbered section and clarify language.
- Section 018 and 019: Renumbered section. Removed unnecessary language, updated terminology and updated acronyms.
- Section 020 and 021: Renumbered sections. Removed unnecessary language, updated terminology, and corrected typographical error.
- Section 022: Renumbered section. Added clarifying language, removed unnecessary language, and updated terminology.
- Section 023: Added clarifying language and removed unnecessary language. Updated terminology.
- Section 024: Renumbered section. Added clarifying language and removed unnecessary language. Updated terminology.
- Section 025 and 026: Renumbered sections. Removed unnecessary language, and updated terminology.
- Section 027: Renumbered section, removed two obsolete sections, removed unnecessary language, clarified language, corrected punctuation, updated section headings, and updated terminology.
- Section 028: Added new section detailing the requirements for hospital providers participating in Nebraska Medicaid that do not comply with the Hospital Quality Assurance and Access Assessment Act, Neb. Rev. Stat. § 68-2103, (LB1087, 2024).

B. Why is the rule necessary? Explain and provide an identification of authorizing statute(s) or legislative bill(s).

1. Update of regulation (repeal of obsolete statutes, reflect current policy, editing or technical language changes, etc.)

Update of regulations to comply with:

- Hospital Quality Assurance and Assessment Act: Neb. Rev. Stat. § 68-2103 (LB1087, 2024)
- Non-acute Admin Days: Neb. Rev. Stat. § 68-1009
- Long-Term Acute Care Hospitals (LTACH): Neb. Rev. Stat. § 68-9,102
- Rural Emergency Hospitals: Neb. Rev. Stat. §§ 71-401 et. seq.
- Hospital Inpatient Nursing Facility Level of Care (LOC): Neb. Rev. Stat. § 68-1009

2. Annual changes – cost of living, hunting season schedules, etc.

   No.

3. Law was changed – federal ___ or state _X__ [Cite authorizing statute(s) or legislative bill(s)]

   The following changes being proposed in these regulations stem from the corresponding sections of Nebraska Revised Statutes:

   - Hospital Quality Assurance and Assessment Act: Neb. Rev. Stat. § 68-2103 (LB1087, 2024)
   - Non-acute Admin Days: Neb. Rev. Stat. § 68-1009
   - Long Term Acute Care Hospitals (LTACH): Neb. Rev. Stat. § 68-9,102
   - Rural Emergency Hospitals: Neb. Rev. Stat. §§ 71-401 et. seq.
   - Hospital Inpatient Nursing Facility Level of Care (LOC): Neb. Rev. Stat. § 68-1009

4. Extension of established policy or program, new initiatives or changes in policy (within statutory authority) Yes.

5. Constituent initiated No.

6. Financial needs – increases/decreases in fees No.

7. Litigation requires changes in rules No.

8. Addresses legal or constitutional concerns of Attorney General's office No.

9. Implements federal or court mandate No.

10. Other (explain)

C. <u>What happens if these rules are not adopted?</u>

The regulations would not be in compliance with:

- Hospital Quality Assurance and Assessment Act: Neb. Rev. Stat. § 68-2103 (LB1087, 2024)
- Non-acute Admin Days: Neb. Rev. Stat. § 68-1009
- Long Term Acute Care Hospitals (LTACH): Neb. Rev. Stat. § 68-9,102
- Rural Emergency Hospitals: Neb. Rev. Stat. §§ 71-401 et. seq.

Additionally, the regulations would continue to not reflect current requirements, and would continue to have outdated terminology. Without these regulations, hospitals will continue to face fiscal concerns without the help of new tools available to the Nebraska Medicaid program.

D. Policy Checklist

1. Is this an update or editorial change reflecting essentially no change in policy? No.

2. Does the policy in the proposed regulation reflect legislative intent?

   Yes.

3. Is the policy proposed in the regulation a state mandate on local government? No. Is it funded? N/A.

4. Is the policy proposed in the regulation a federal mandate on local government? No. Is it funded? N/A.

E. Fiscal Impact. In addition to completing the required Fiscal Impact Statement (a copy must be attached to this document), the agency must address the following:

2. Will the proposed regulation reduce, increase, or have no change in resources – funds, personnel or FTE? Increases to expenditures and revenues, as well as one FTE, which have already accounted for through passed legislation in 2023 and 2024.

   The fiscal impact stemming from these proposed regulations are due to two main impacts:

   - Hospital Quality Assurance and Access Assessment Act, Neb. Rev. Stat. § 68-2103 (LB1087, 2024): Total Fund Expenditures are estimated at $1.41 billion per year. There is an estimated increase in federal expenditures associated with these changes of approximately $969 million annually. There is no state general fund impact estimated as the non-federal share of the program is funded through the established hosptial assessment, which is expected to generate approximately $475 million per year in revenue. While

there is a new cost to the state of one FTE of approximately $72,791, this cost will be covered by the assessment revenue and federal financial participation.

- Non-acute Admin Days, Neb. Rev. Stat. § 68-1009 (LB227 § 63, 2023): There is an estimated increase in expenditures annually of approximately $3,081,341 in total funds, and payments would be eligible for the applicable federal financing match of the beneficiary.

3. Have initial contacts been made with citizens or organizations that may be impacted by the proposed regulation? Yes. Nebraska Medicaid has been in communication with the Nebraska Hospital Association and hospitals across the state during the development of these proposed regulations.

4. Does the proposed regulation impact another agency? No. Explain the impact. N/A.

5. Will the proposed regulation reduce, increase, or have no change on reporting requirements of businesses? There will be an increase in federal reporting requirements tied to the Hospital Quality Assurance and Access Assessment Act, Neb. Rev. Stat. § 68-2103 (LB1087, 2024).

   Through this new assessment program, hospitals participating in the Nebraska Medicaid program will be required to submit quarterly quality metric reports to the Nebraska Hospital Association, who will then pass along these reports to the Nebraska Medicaid program. Nebraska Medicaid is required to submit these quarterly reports to the federal government as a condition of approval for this program.

5. What is the agency's best estimate of the additional or reduced spending? If there is none, please note. If receipt of federal funds is contingent upon approval of the proposed regulation, then indicate the amount and nature of the federal funds affected, and enclose laws or correspondence from federal officials substantiating the information.

   Hospital Quality Assurance and Access Assessment Act, Neb. Rev. Stat. § 68-2103 (LB1087, 2024): there is an estimated increase in total fund expenditures of $1.41 billion in total funds annually. Federal expenditures associated with these changes of approximately $969 million annually. There is not an estimated increase in state expenditures for these changes as the non-federal share of the payments is hospital assessments, which are primarily used as the source for matching the additional federal financial participation for payments to providers. The state estimates collecting approximately $475 million annually in assessment revenue as the source of the non-federal share. In addition, small portions of the assessment collected under this assessment are allowed to be used by Nebraska Medicaid as detailed in Neb. Rev. Stat. § 68-2103 (LB1087, 2024). This

includes revenue for program 348 not to exceed $17.5 million per year; revenue for program 033 not to exceed $15 million per year; and revenue to the Nebraska Center for Nursing Board not to exceed $2.5 million per year.

Hospital Inpatient Nursing Facility Level of Care (LOC): there is an estimated increase in expenditures annually of approximately $3,081,341 in total funds. Appropriations were provided as part of the passage of Neb. Rev. Stat. § 68-1009. (LB227 § 63 (2023)).

Long-Term Acute Care Hospitals: there is no estimated fiscal impact for these changes as Nebraska Medicaid already reimburses long-term acute care hospitals under other current hospital peer group payment methodologies and these changes transition them to a new provider type and specialty.

Rural Emergency Hospitals: there is no estimated fiscal impact for these changes as Nebraska Medicaid already reimburses critical access hospitals and is proposing reimbursing this new provider type and specialty consistent with historical reimbursement.

6. Include a description of the impact that the proposed regulation will have on the number of state employees and how the agency intends to address proposed increases or decreases in FTE.

   The Hospital Quality Assurance and Access Assessment Act, Neb. Rev. Stat. § 68-2103 (LB1087, 2024) does require one additional FTE. The Department has already created the position. This position will be a Reimbursement Analyst with a new cost to the state of approximately $72,791.

F. Unique problems or issues and recommendations.

Nebraska Medicaid has worked with relevant stakeholders, including providers, their representatives, Nebraska Hospital Association and hospitals across the state, and our contracted managed care plans to ensure our proposed regulations are not overly burdensome for affected parties. As stakeholders have thus far generally been in agreement, Nebraska Medicaid does not anticipate any unique problems or issues related to these regulations.

G. Who is expected to be affected, or to oppose or support the proposed regulation? Explain what initial informal contacts have been made with organizations or citizens who may be affected by the regulation prior to the public hearing.

Nebraska Medicaid anticipates that stakeholders, including providers, their representatives, Nebraska Hospital Association and hospitals across the state, and our contracted managed care plans will generally support these proposed regulations. Throughout the development of these proposed regulations, Nebraska Medicaid has worked with hospital providers and their associations to ensure that these proposed regulations align with their needs. These proposed regulations will provide new ways hospitals can deliver care to Nebraska Medicaid beneficiaries and similarly provide new reimbursement methods to help the fiscal sustainability of these facilities across the state. These proposed regulations will help sustain access to health care across the state, both for Nebraska Medicaid beneficiaries in particular and the community at large. Additionally, Nebraska Medicaid has worked with the contracted managed care plans to ensure they understand Nebraska Medicaid's proposed regulations and would be able to implement the new proposed requirements.

The legislative requirements being implemented through these regulations, Neb. Rev. Stat. § 68-2103 (LB1087, 2024), were supported without opposition in the Nebraska Legislature, and as such Nebraska Medicaid does not anticipate opposition from legislators.

DHHS will solicit public comment on the proposed regulations before the public hearing.

H. **Are these proposed rules a likely candidate for negotiated rulemaking? Explain. Has the process been completed? If so, explain how the issues were addressed.**

No.

DHHS Division Director's Verification of Review

I have reviewed these proposals and verify that, at this stage of the regulation's development, these questions have been accurately addressed.

Drew Gonshorowski
Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

12·12·2025
Date

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 10 HOSPITAL SERVICES

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

002. DEFINITIONS. The following definitions apply:

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

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

002.03 AMBULATORY ROOM AND BOARD. Accommodations for families and beneficiaries undergoing acute, long-term inpatient or outpatient hospital treatment. To qualify for this service, the location of the hospital where the beneficiary is receiving care must be 90 miles or greater from the beneficiary's or family's home.

002.04 ANCILLARY SERVICES. Ancillary services are supportive or diagnostic measures that supplement and support a primary physician, nurse, or other healthcare provider in treating a patient.

002.~~03~~05 BASE YEAR. The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

002.~~04~~06 CAPITAL-RELATED COSTS. Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

002.~~05~~07 CASE-MIX INDEX. An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

002.08 CLINICAL TRIALS. For services not subject to Food and Drug Administration (FDA) approval, clinical trials fall into one of three phases.

002.08(A) PHASE I CLINICAL TRIALS. Initial introduction of an investigational service into humans.

002.08(B) PHASE II CLINICAL TRIALS. 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.

002.08(C) PHASE III CLINICAL TRIALS. Clinical studies to further evaluate the effectiveness and safety of a service that is needed to evaluate the overall risk or benefit and to provide an adequate basis for determining patient selection criteria for the service

as the recommended standard of care. These studies usually compare the new service to the current recommended standard of care.

002.~~06~~09 COMORBIDITY. The simultaneous presence of two chronic diseases, or conditions, in a patient.

002.~~07~~10 COORDINATION PLAN. An overall program outline for the delivery of a specific service; it is not an individual patient care plan.

002.~~08~~11 COST OUTLIER. Cases which have an extraordinarily high cost as established in this title ~~471 Nebraska Administrative Code (NAC) 10-004.03~~ as eligible for additional payments above and beyond the initial diagnosis-related group (DRG) payment.

002.~~09~~12 CRITICAL ACCESS HOSPITAL (CAH). A hospital licensed as a critical access hospital (CAH) by the Department of Health and Human Services, Division of Public Health, ~~under 175 NAC 9,~~ and certified for participation by Medicare as a critical access hospital (CAH).

002.~~10~~13 DIAGNOSIS-RELATED GROUP (DRG). A group of similar diagnoses combined based on patient age, birth weight, procedure coding, comorbidity, and complications.

002.~~11~~14 DIAGNOSIS-RELATED GROUP (DRG) WEIGHT. A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each diagnosis-related group (DRG) and severity of illness ~~(SOI)~~.

002.~~12~~15 DIAGNOSTIC SERVICE. An examination or procedure performed either on the patient, or materials obtained from the patient, to provide information for the diagnosis or treatment of a disease or to assess a medical condition. This may include radiological and pathological services.

002.~~13~~16 DIALYSIS. A process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane.

002.~~14~~17 DIRECT MEDICAL EDUCATION (DME) COST PAYMENT. An add-on to the operating cost payment amount to compensate for direct medical education (DME) costs associated with approved intern and resident programs. ~~Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.~~

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

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

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

002.~~16~~18 DISTINCT PART UNIT. A Medicare-certified hospital-based substance ~~ab~~use disorder, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

002.~~17~~19 DURABLE MEDICAL EQUIPMENT. Equipment which withstands repeated use is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury and is appropriate for use in the beneficiary's ~~in's~~ home.

002.~~18~~20 EMERGENCY MEDICAL CONDITION. A medical or behavioral condition, the onset of which is sudden, manifesting itself by symptoms of sufficient severity such that the absence of immediate medical attention could result in:

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

002.21 EXTENDED STAY. An inpatient hospital stay during which a beneficiary no longer requires acute in-patient care, and more than five days for discharge planning have passed.

002.~~19~~22 HEALTH CARE-ACQUIRED CONDITIONS (HAC). A health care-acquired condition (HAC) means a condition occurring in any inpatient hospital setting, identified as a hospital-acquired condition (HAC) by Medicare that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission ~~other than deep vein thrombosis (DVT) or pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients~~.

002.~~20~~23 HOSPITAL EMERGENCY SERVICES. Services that are necessary to prevent the death of the ~~client~~ beneficiary or serious impairment of the ~~client's~~ beneficiary's health and, because of the threat to the life or health of the beneficiary ~~client~~, necessitate the use of the most accessible hospital equipped to provide the necessary services.

002.~~21~~24 HOSPITAL INPATIENT SERVICES. Services that:

(A) Are ordinarily furnished in a hospital for the care and treatment of inpatients;
(B) Are furnished under the direction of a physician or dentist;
(C) Are furnished in an institution that:
    (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
    (ii) Is licensed or formally approved as a hospital by an officially designated authority for ~~S~~state standard-setting;
    (iii) Is enrolled with and certified by Medicare ~~Meets the requirements~~ for participation ~~in Medicare~~ as a hospital; and
    (iv) Has in effect a utilization review (UR) plan, applicable to all Nebraska Medicaid ~~patients~~ beneficiaries, that meets the requirements ~~of 42 Code~~ of ~~F~~federal ~~R~~regulations ~~(CFR) §~~482.30, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services; and
(D) Do not include special needs facilities ~~(SNF)~~ and independent clinical laboratory ~~(ICF)~~ services furnished by a hospital with a swing-bed approval.

002.~~22~~25 HOSPITAL MERGERS. Hospitals that have combined into a single entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Nebraska Medicaid provider number.

002.~~23~~26 HOSPITAL OUTPATIENT OBSERVATION SERVICES. Outpatient ~~O~~observation services are those services furnished by a hospital on the hospital premises, including use of a bed and periodic monitoring by a hospital's nursing staff or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Some ~~patients~~ beneficiaries may require a second day of outpatient observation services. A maximum of 48 hours of outpatient observation may be reimbursed. When a ~~client~~ beneficiary receives hospital outpatient observation services and is thereafter admitted as an inpatient of the same hospital, the hospital observation services are included in the hospital's payment for the inpatient services.

002.~~24~~27 HOSPITAL OUTPATIENT SERVICES. Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients under the direction of a physician, optometrist, ophthalmologist, audiologist, or dentist in an institution that meets provider requirements.

002.~~25~~28 HOSPITAL-AFFILIATED AMBULATORY SURGICAL CENTER (HAASC). An ambulatory surgical center (ASC) operated by a hospital. A hospital-affiliated ambulatory surgical center (HAASC) may be covered under Medicare, and therefore under Nebraska Medicaid, as an ambulatory surgical center (ASC) or a hospital-affiliated ambulatory surgical center (HAASC).

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

002.~~27~~29 HOSPITAL-SPECIFIC BASE YEAR OPERATING COST. Hospital-specific operating allowable cost associated with treating Nebraska Medicaid ~~patients~~ beneficiaries. 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 (DME) costs, ~~and~~ indirect medical education (IME) costs, and graduate medical education costs.

002.~~28~~30 HOSPITAL-SPECIFIC COST-TO-CHARGE RATIO (CCR). Hospital-specific cost-to-charge ratio (CCR) is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-specific cost-to-charge ratios (CCR) used for outlier cost payments and transplant diagnosis-related group (DRG) cost-to-charge ratio (CCR) payments are derived from the outlier cost-to-charge ratios (CCR) in the Medicare inpatient prospective payment system.

002.~~29~~31 INDEPENDENT CLINICAL LABORATORY ~~(ICF)~~. A laboratory which is operated by or under the supervision of a hospital or the organized medical staff of the hospital which does not meet the definition of a hospital is considered to be an independent laboratory. However, a laboratory serving hospital inpatients and outpatients and operated on the premises of a hospital which meets the definition of a hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not classified as an independent clinical laboratory. The hospital's certification covers the services performed in this laboratory.

002.~~30~~32 INDIRECT MEDICAL EDUCATION (IME) COST PAYMENT. Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education cost payments.

002.~~31~~33 INFANT OR INFANCY. The time period from an individual's birth through completion of one year of age.

002.~~32~~34 INPATIENT. A ~~patient~~ beneficiary who has been admitted to a medical institution as an inpatient on the recommendation of a physician or dentist and who:

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

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

002.~~33~~35 INPATIENT DAYS. The number of days of care covered for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Nebraska Medicaid reporting purposes, even if the hospital uses a different definition of a day for statistical or other purposes. The day of admission is counted as a full day.

002.~~33~~35(A) PART OF DAY. Except for the day of admission, a part of a day, including the day of discharge, death, or a day on which a ~~patient~~ beneficiary 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~~ beneficiary begins a leave of absence are covered. If inpatient admission and discharge or death occurs on the same day, the day is considered a day of admission and counted as one inpatient day.

002.~~33~~35(B) ANCILLARY AREAS. When a registered inpatient is occupying any other ancillary area, such as surgery or radiology, at the census-taking hour before occupying an inpatient bed, the ~~patient~~ beneficiary must be included in the inpatient census of the routine care area, not the ancillary area.

002.~~33~~35(C) MEDICARE METHODOLOGY. The ~~Department utilizes the current Medicare~~ methodology that Medicare requires to be used to ~~in~~ account~~ing~~ for ~~the~~ inpatient accommodations on the ~~Nebraska~~ Medicare cost report.

002.36 LONG-TERM ACUTE CARE HOSPITAL (LTACH). A hospital that is licensed as a general acute care hospital that focuses on treating patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. Patients treated in a long-term acute care hospital (LTACH) are not generally appropriate for lower level of care (LOC) settings but are expected to improve to lower level of care (LOC) status.

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

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

~~period, divided by the total amount of revenues of the hospital for inpatient services, including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals in the same cost reporting period; and~~

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

002.~~35~~37 NEBRASKA MEDICAID ALLOWABLE INPATIENT CHARGES. Nebraska Medicaid allowable inpatient charges equal the ~~T~~total claim submitted charges less the ~~claim~~ non-allowable amount.

002.~~36~~38 NEBRASKA MEDICAID ALLOWABLE INPATIENT DAYS. Nebraska Medicaid allowable inpatient days are ~~T~~the total number of covered Nebraska Medicaid inpatient days.

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

002.~~38~~39 NEBRASKA MEDICAID RATE PERIOD. The period of July 1 through the following June 30.

002.~~39~~40 MEDICAL NECESSITY. Health care services and supplies which are medically appropriate and:

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

002.~~40~~41 MEDICAL REVIEW. Review of Nebraska Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay~~,~~; completeness~~,~~; adequacy~~,~~; ~~and~~ quality of care; appropriateness of admission~~,~~; discharge and transfer; and appropriateness of prospective payment outlier cases.

002.4142 MEDICAL SOCIAL SERVICES. Medical social services are those social services which contribute meaningfully to the treatment of a ~~patient's~~ beneficiary's condition. ~~These services include, but are not limited to:~~

~~(A) Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the hospital;~~

~~(B) Appropriate action to obtain case work services to assist in resolving problems in these areas; and~~

~~(C) Assessment of the patient's medical and nursing requirements, his or her home situation, his or her financial resources, and the community resources available to him or her in making the decision regarding their discharge.~~

002.4243 MEDICAL SUPPLIES. Expendable or specified reusable supplies required for care of a medical condition and used in the beneficiary's ~~client's~~ home must be prescribed by a physician or other licensed practitioner within the scope of their licensure. This includes dressings, colostomy supplies, catheters, and other similar items.

002.4344 MEDICARE COST REPORT. The report filed by each facility with its Medicare intermediary. A hospital that does not participate in the Medicare program will complete the Medicare cost report in compliance with Medicare principles and supporting rules, regulations, and statutes. The hospital will file the completed form with Nebraska Medicaid 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 Nebraska Medicaid or its designees. If a nursing facility is affiliated with the hospital, the nursing facility cost report must be filed as outlined in these regulations. ~~The Medicare cost report is available through the National Technical Information Service.~~

002.4445 NEONATAL INTENSIVE CARE. Intensive care services provided to an infant in an intensive care unit specially equipped to care for infants.

002.4546 NEW OPERATIONAL FACILITY. 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. A new operating facility provides~~ing~~ inpatient hospital care ~~which~~ that meets one of the following criteria:

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

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

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

002.4647 NON-PATIENT. A~~n individual~~ beneficiary 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~~ beneficiary is not registered as an inpatient or an outpatient of the hospital. If the sample is obtained by hospital personnel, the tests are outpatient services.

002.4748 NURSERY CARE. Services for a newborn child from time of birth to time of discharge of the mother from the facility.

002.4849 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 (DME) costs, and ~~indirect~~ graduate medical education costs.

002.4950 OTHER PROVIDER-PREVENTABLE CONDITIONS (OPPC). A wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

002.5051 ORTHOTICS. Rigid or semi-rigid devices to prevent or correct physical deformity or malfunction, to support a weak or deformed part of the body, or to eliminate motion in a diseased or injured part of the body.

002.5152 OUTPATIENT. A person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services.

002.5253 PASS OR LEAVE OF ABSENCE. A patient is absent from the hospital but has not been discharged from the facility. A hospital may place a patient on a leave of absence when readmission is expected, and the patient does not require a hospital level of care during the interim period.

002.5354 PATHOLOGICAL SERVICES. Microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or other pathological examinations or procedures performed on materials obtained from the patient to provide information for the diagnosis or treatment of a disease or an assessment of the medical condition of the patient.

002.5455 PRESENT ON ADMISSION (POA) INDICATOR. A status code the hospital uses on an inpatient claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs.

002.5556 PROSTHETIC. A device which replaces a missing part of the body.

002.5657 PROVIDER-PREVENTABLE CONDITIONS (PPC). An umbrella term which is defined as two distinct categories: health care-acquired conditions (HCAC) and other provider-preventable conditions (OPPC).

002.5758 RADIOLOGICAL SERVICES. Services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic purposes and associated medical services necessary for the diagnosis and treatment of the patient.

002.5859 REPORTING PERIOD. Same reporting period as that used for its Medicare cost report.

002.5960 RESOURCE INTENSITY. The relative volume and types of diagnostic, therapeutic, and bed services used in the management of a particular disease.

002.6061 RISK OF MORTALITY (ROM). The likelihood of dying.

002.62 RURAL EMERGENCY HOSPITAL. A hospital licensed as a rural emergency hospital by the Department of Health and Human Services, Division of Public Health, and certified for participation by Medicare as a rural emergency hospital. A rural emergency hospital solely provides outpatient services, including emergency department services, observation care, and additional outpatient medical and health services that do not exceed an annual per patient length of stay of 24 hours on average.

002.~~61~~63 SEVERE OBESITY. Body Mass Index greater than 35.

002.~~62~~64 SEVERITY OF ILLNESS LEVEL ~~(SOI)~~. The extent of physiologic decompensation or organ system loss of function.

002.65 SWING BED. Post-hospital 24-hour skilled nursing care services that must be provided by or under the direct supervision of professional or technical personnel and requires skilled knowledge, judgment observation, and assessment.

002.66 SWING BED FACILITY. A rural acute hospital which is certified to provide skilled nursing facility (SNF) level of care.

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

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

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

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

002.~~64~~67 TAX-RELATED COSTS. Any real or personal property tax, sales tax, excise tax, tax enacted pursuant to federal public laws ~~the Medicaid Voluntary Contribution Provider Specific Tax Amendment of 1991 (P.L. 102-234)~~ or any amendments thereto, franchise fee, license fee, or hospital specific tax, fee or assessment imposed by the local, state, or federal government, but not including income taxes.

002.~~65~~68 THERAPEUTIC SERVICES. Services and supplies which are not diagnostic services, are furnished incident to the services of physicians and practitioners, and which aid physicians and practitioners in the treatment of patients.

002.69 TRANSPLANT DIAGNOSIS-RELATED GROUPS (DRG). Transplant diagnosis-related groups (DRG) are identified in the All-Patient Refined Diagnosis-Related Group (APR DRG). Nebraska Medicaid does not recognize bone marrow transplant diagnosis-related groups in its classification with all other transplant diagnosis-related groups categorized by the All-Patient Refined Diagnosis-Related Group (APR DRG). Bone marrow transplant diagnosis-related groups do not receive a transplant cost-to-charge ratio or transplant direct medical education (DME) payment. The bone marrow transplant diagnosis-related groups per discharge payment is the sum of the operating cost payment amount, the capital-related cost

payment, and when applicable a direct medical education (DME) cost payment, indirect medical education (IME) cost payment, and a cost outlier payment.

002.~~66~~70 UNCOMPENSATED CARE. Uncompensated care includes the difference between costs incurred and payments received in providing services to Nebraska Medicaid ~~patients~~ beneficiary and uninsured.

002.~~67~~71 WARD. Either:

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

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

003. PROVIDER REQUIREMENTS.

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

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

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

(ii) Be licensed as a hospital by the Department of Health and Human Services, Division of Public Health or the officially designated authority for state standard-setting in the state where the hospital is located;

(iii) Have licensed and certified hospital beds; and

(iv) ~~Meet the requirements for participation in~~ Be enrolled with Medicare as a hospital ~~and Medicaid~~.

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

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

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

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

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

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

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

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

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

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

(1) The charge to ~~the Department~~ Nebraska Medicaid 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 beneficiaries ~~clients~~ in the ambulatory room and board facility; or
(4) Other substantial changes are made to the hospital's ambulatory room and board services.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

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

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

004.01(B) PRIOR AUTHORIZATION. ~~The Department requires that p~~Physicians must request prior authorization from ~~the Department~~ Nebraska Medicaid before providing:

(1) Medical transplants;
(2) Abortions;
(3) Cosmetic and reconstructive surgery;
(4) Bariatric surgery for obesity;
(5) Out-of-~~S~~state ~~S~~services~~.~~, except emergency services provided out-of-state ~~Exception: Prior authorization is not required for emergency services~~;
(6) Established procedures of questionable current usefulness;
(7) Procedures which tend to be redundant when performed in combination with other procedures;
(8) New procedures of unproven value;
(9) Certain drug products;
(10) ~~Sleep study for a child under the age of six years old~~ All attended sleep studies; and
(11) Ventricular ~~A~~assist ~~D~~devices.

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

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

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

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

004.01(B)(i)(~~3~~2) NOTIFICATION PROCESS. Upon determination of approval or denial, ~~the Department provides~~ a written response is provided to the following, as applicable, and depending on the source of the request:

(a) Physician(s) submitting or contributing to the request;
(b) Caseworker or case manager; and
(c) Medical ~~R~~review ~~O~~organization when appropriate.

004.01(B)(ii) VERBAL AUTHORIZATION PROCEDURES. ~~The Department may issue a~~ A verbal authorization may be issued when circumstances are of an emergency nature, or urgent to the extent that a delay would place the beneficiary ~~client~~ at risk of not receiving medical care. When a verbal authorization is granted, a written request ~~or electronic request using the standard electronic Health Care Services Review – Request for Review and Response transaction~~ must be submitted

within 14 days of the verbal authorization. ~~A written or electronic response from the Department will be issued upon completion of the review.~~

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

004.02 SPECIFIC REQUIREMENTS.

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

(i) ~~Medical Transplants:~~ Transplants continue to require prior authorization by ~~the Department~~ Nebraska Medicaid and are reimbursed on a fee-for-service basis, outside the managed care organization's (MCO) capitation payment;

(ii) ~~Abortions:~~ Abortions require prior authorization by ~~the Department~~ Nebraska Medicaid and are included in the capitation fee for the managed care organization (MCO); and

(iii) ~~Family Planning Services:~~ The beneficiary ~~client~~ must be able to obtain family planning services upon request and from any appropriate provider who is enrolled in Nebraska Medicaid. Family planning services are reimbursed by the managed care organization (MCO), regardless of whether the service is provided by a primary care provider (PCP) enrolled with the managed care organization (MCO) or a family planning provider outside the managed care organization (MCO).

004.02(B) PRIOR AUTHORIZATION FOR TRANSPLANT SERVICES. ~~The Department requires~~ Transplant services are reimbursed on a fee-for-service basis. ~~p~~Prior authorization is required ~~of~~ for all transplant services. Physicians must request prior authorization before performing any transplant service or related donor service.

004.02(B)(i) PRIOR AUTHORIZATION REQUIREMENTS. Prior authorization requests must include, at a minimum:

(1) The patient's name, Nebraska Medicaid identification number ~~ID~~, and date of birth;

(2) Diagnosis, pertinent past medical history and treatment, prognosis with and without the transplant, and the procedure(s) for which the authorization is requested;

(3) Name of the hospital, city, and state where the service(s) will be performed, including the National Provider Identification number of the provider. All providers must be enrolled with Nebraska Medicaid before services are performed. ~~Out-of-state services are covered in accordance with 471 NAC 1~~;

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

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

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

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

(c) A written statement by the physician:

(i) Recommending the transplant;

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

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

004.02(C) PRIOR AUTHORIZATION FOR ~~GASTRIC BYPASS~~ BARIATRIC SURGERY. Prior authorization requests must include~~, but is not limited to,~~ documentation of all of the following:

(i) Medical diagnoses;

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

(1) Type 2 Diabetes Mellitus ~~(~~includeing recent lab results and current medications~~)~~;

(2) Medically refrectory ~~H~~hypertension ~~(~~includeing current medications, ~~including~~ antihypertensive, and blood pressure readings~~)~~;

(3) Hyperlipidema including recent lab results and current medications;

(4) Cardiovascular disease;

~~(3)~~(5) Coronary Artery Disease~~, Congestive Heart Failure, or dyslipidemia (include recent lab results and current medications)~~;

~~(4)~~(6) Obstructive sleep apnea ~~(~~includeing sleep study results and treatment~~)~~;

(7) Obesity-hypoventilation syndromes;

~~(5)~~(8) Gastroesophageal Reflux Disease ~~(~~includeing test results and current medications ~~being used to manage the symptoms)~~;

~~(6)~~(9)Osteoarthritis ~~(~~includeing information about the beneficiary's ~~client's~~ ability to ambulate, assistive devices used, and any medications ~~being used to manage symptoms)~~; or

~~(7)~~(10)Idiopathic intracranial hypertension ~~P~~pseudo tumor cerebri ~~(include diagnostic reports/imaging)~~; ~~or~~ and

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

(iii) ~~Dietary consultation, including documentation showing completion of a supervised diet program for six months or more, and a determination that the patient is motivated to comply with dietary changes;~~ Preoperative evaluation within six months of the scheduled surgery must include:

(1) Nutritional consultation that includes:

(a) Diet and physical activity history and patterns of previous weight loss and regain;

(b) Counseling on steps to modify current problem eating behaviors;
(c) Counseling on postoperative dietary modifications; and
(d) Determination of the beneficiary's motivation to comply with dietary modifications to reduce the risk of postoperative complications;

(2) Psychiatry or psychology consultation that includes:
(a) Evaluation of the beneficiary to determine readiness for surgery and lifestyle change;
(b) Assessment for major mental health disorders, psychosocial functioning, alcohol and substance use disorder, and maladaptive eating behaviors; and
(c) Adequate treatment as needed, to maximize successful postoperative outcomes; and

(3) Medical clearance that includes:
(a) Evaluation of cardiac and pulmonary risk;
(b) Nutritional, hormonal, and other lab parameters as indicated;
(c) No history of tobacco use, or tobacco cessation has been attempted prior to surgery; and
(d) Beneficiary's understanding of surgical risk, postoperative compliance, and follow-up.

~~(iv) Psychiatry or psychology consultation that includes:~~
~~(1) Evaluation to determine readiness for surgery and lifestyle change; and~~
~~(2) No behavior health disorder by history and physical exam:~~
~~(a) Exam includes no severe psychosis or personal disorder; and~~
~~(b) Mood or anxiety disorder excluded and treatment (if treated, include treatment medications or modalities).~~

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

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

004.03 COVERED INPATIENT SERVICES.

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

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

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

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

the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

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

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

004.03~~(E)~~(D) OUTPATIENT~~/~~ OR EMERGENCY SERVICES. When a beneficiary ~~client~~ receives hospital outpatient or emergency room services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the hospital outpatient or emergency room services are covered by ~~the Department~~ Nebraska Medicaid as inpatient services. Hospital outpatient services furnished in the outpatient or emergency room to a ~~patient~~ beneficiary classified as ~~"~~dead on arrival~~"~~ are covered through pronouncement of death, providing the hospital considers these ~~patients~~ beneficiaries 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~~ beneficiary was pronounced dead before arrival at the hospital.

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

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

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

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

(3) The portion of the outside blood source's blood fee which remains after credit is given for replacement.

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

004.03(H) LONG-TERM ACUTE CARE HOSPITAL (LTACH) SERVICES. Long-term acute care hospital (LTACH) admission may be considered when continued daily monitoring and complex medical intervention is required for the complex medical condition(s). Prior authorization is required for long-term acute care level of care (LOC).

004.04 DRUGS.

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

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

004.05 MEDICAL SUPPLIES AND EQUIPMENT.

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

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

004.05(C) TAKE-HOME SUPPLIES AND EQUIPMENT. ~~The Department covers t~~The following supplies and equipment are covered:

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

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

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

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

004.06 LABORATORY AND PATHOLOGY.

004.06(A) PROFESSIONAL COMPONENT. ~~The Department covers as a physician's service t~~The professional component of laboratory services provided by a physician is covered to an individual patient in accordance with ~~the~~ this title ~~provisions of 471 NAC 18~~. The professional component must be billed on the appropriate Nebraska Medicaid approved health care claim form ~~Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837)~~.

004.06(B) CLINICAL LAB SERVICES. Clinical laboratory services are considered technical components and must be billed as such. ~~The Department covers t~~The technical component of clinical laboratory services provided to hospital inpatients, outpatients, and non-patients performed by non-physicians manually or using automated laboratory equipment is covered. 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~~ inpatient service costs on its cost report to be considered in calculating the hospital's payment rate.
(2) ~~Outpatient Services: Payment is made at the fee schedule determined by Centers for Medicare and Medicaid Services.~~ Outpatient clinical laboratory services must be itemized on the appropriate claim form or electronic format using the appropriate ~~h~~Healthcare ~~c~~Common ~~p~~Procedure ~~c~~Coding ~~s~~System (HCPCS) procedure codes. Payment is made pursuant to ~~or based on~~ the fee schedule determined by Centers for Medicare & Medicaid Services (CMS).
(3) ~~Non-Patient Services:~~ Payment is made ~~at~~ ~~P~~pursuant to the fee schedule determined by Centers for Medicare ~~and~~ & Medicaid Services (CMS) for non-patient services.

004.06(B)(i) LEASED DEPARTMENTS. Leased department status has no bearing on billing or payment for clinical lab services. The hospital must claim all clinical lab services, whether performed in a leased or non-leased department. Payment for the total service, which includes the ~~(~~professional and technical component~~)~~, is made to

the hospital. ~~The Department does not make s~~Separate payment is not made for the professional component for clinical lab services.

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

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

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

004.06(C)(ii) BILLING AND PAYMENT FOR HOSPITAL OUTPATIENT ANATOMICAL PATHOLOGY SERVICES. The hospital must bill the technical component of outpatient anatomical pathology services in a summary bill format using the appropriate revenue code on the appropriate claim form or electronic format. The pathologist must claim the professional component on the appropriate Nebraska Medicaid approved health care claim form ~~Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837)~~ using the appropriate H~~h~~ealthcare C~~c~~ommon P~~p~~rocedure S~~s~~ystem P~~p~~rocedure C~~c~~ode (HCPCS) and modifier ~~and a "26" modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule~~.

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

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

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

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

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

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

004.07(~~B~~A) 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~~ beneficiary; and
(2) Hospital services.

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

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

004.07(~~D~~B) NON-PHYSICIAN SERVICES AND ITEMS. All non-physician services, drugs, medical supplies, and items, provided to hospital inpatients or outpatients must be provided directly by the hospital or under arrangements. If the services or items are

provided under arrangements, the hospital is responsible for payment to the non-physician provider or supplier. ~~The Department prohibits t~~The "~~unbundling~~" of costs by hospitals for non-physician services or supplies provided to hospital patients is prohibited, including ancillary services provided by another hospital.

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

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

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

~~004.08(C) COMPUTERIZED TOMOGRAPHY (CT) SCANS. The Department covers diagnostic examinations of the head and of certain other parts of the body performed by computerized tomography (CT) scanners when:~~

~~(i) Medical and scientific literature and opinion support the use of a scan for the condition;~~

~~(ii) The scan is reasonable and necessary for the individual patient; and~~

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

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

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

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

004.08(C)(i) SCREENING MAMMOGRAPHY. One screening mammogram is covered annually according to the periodicity schedule and guidelines of the American Cancer Society.

004.08(C)(ii) DIAGNOSTIC MAMMOGRAPHY. Diagnostic mammograms are covered based on the medical necessity of the service.

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

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

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

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

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

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

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

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

004.08~~(E)~~(D)(iv)(1) NEBRASKA PORTABLE X-RAY PROVIDER. The provider must submit the appropriate Nebraska Medicaid approved certification form ~~Form CMS-1539: Medicare/Medicaid Certification and Transmittal~~.

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

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

004.08~~(E)~~(D)(v)(1) CONDITIONS OF COVERAGE NOTIFICATION. When the services of a provider of portable x-ray services no longer meet the conditions of coverage, physicians responsible for supervising the portable x-ray services and having an interest in the x-ray provider's certification status must be notified. The notification action regarding suppliers of portable x-ray equipment is the same as

required for decertification of independent laboratories, and the same procedures are followed.

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

004.08~~(G)~~(F) BILLING AND PAYMENT FOR RADIOLOGY SERVICES.

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

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

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

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

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

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

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

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

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

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

004.10(A) BILLING FOR HOSPITAL-BASED AMBULANCE SERVICES. Hospital-based ambulance services provided to an inpatient or an outpatient must be claimed on the appropriate claim format or electronic format as a hospital outpatient service by the hospital-based ambulance provider. Hospital-based ambulance services are reimbursed as a hospital outpatient service. Hospital-based ambulance costs are not included in the calculations for hospital inpatient rates.

004.10(B) GROUND AMBULANCE SERVICES. Nebraska Medicaid covers basic life support and advanced life support ambulance services. Ground ambulance base rates include all services, equipment, and other costs.

004.10(B)(i) BASIC LIFE SUPPORT (BLS) AMBULANCE. A basic life support (BLS) ambulance provides transportation plus the equipment and staff needed for basic

services ~~such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, cardio-pulmonary resuscitation (CPR), defibrillation, etc~~.

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

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

004.10(C) MILEAGE. ~~Loaded mileage. m~~Miles traveled while the beneficiary ~~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 beneficiary ~~client~~ is outside the limits of the town in which the trip originated. ~~"Unloaded" m~~Mileage traveled while the beneficiary is not present in the ambulance vehicle is included in the payment for the base rate.

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

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

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

004.10(F) AIR AMBULANCE. ~~The Department covers m~~Medically necessary air ambulance services are covered only when transportation by ground ambulance is contraindicated and:

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

004.10(F)(i) BILLING. When billing ~~the Department~~ Nebraska Medicaid, the provider must bill air ambulance services as a single charge which includes base rate and mileage. The number of ~~"loaded"~~ miles traveled while the beneficiary is present must

be included on the claim. If a determination is made that ambulance transport is medically necessary, but ground ambulance would have been appropriate, payment for the air ambulance service is limited to the amount allowable for ground transport.

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

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

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

004.10(G)(i)(1) NON-EMERGENT TRANSPORT. 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 beneficiary's ~~client's residence~~ home.

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

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

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

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

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

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

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

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

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

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

004.11 PRE-ADMISSION TESTING. ~~The Department covers p~~Pre-admission testing and diagnostic services rendered up to three days before the day of admission are covered, as an ancillary service.

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

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

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

(B) The test is medically necessary for the diagnosis or treatment of the individual ~~patient's~~ beneficiary's condition; and

(C) The test does not unnecessarily duplicate:

(i) The same test performed on an outpatient basis before admission; or~~,~~

(ii) The same test performed in connection with a separate, but recent, hospital admission.

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

004.13(A) COVERED SERVICES – PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND SPEECH-LANGUAGE PATHOLOGY SERVICES. ~~The Department covers p~~Physical therapy (PT), occupational therapy (OT), speech-language pathology, and audiology services are covered in accordance with this title. ~~in accordance with the criteria outlined in 471 NAC 17, 471 NAC 14, and 471 NAC 23 respectively.~~

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

004.14 ANESTHESIOLOGY.

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

004.14(A)(i) MEDICAL DIRECTION OF FOUR OR FEWER CONCURRENT PROCEDURES. ~~The Department covers t~~The professional component for the physician's personal medical direction of concurrent anesthesiology services provided by qualified anesthetists is covered, such as certified registered nurse anesthetists (CRNA), in accordance with this chapter ~~471 NAC 10~~. The professional component of personal services up to and including induction is covered as a physician's service and must be billed on the appropriate Nebraska Medicaid approved health care claim form ~~Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837)~~.

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

004.14(B)(i) MEDICAL DIRECTION OF MORE THAN FOUR CONCURRENT PROCEDURES. If the physician is involved in providing direction for more than four concurrent procedures or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are covered as the technical component of the hospital services. The physician must ensure that a qualified individual performs any procedure in which the physician does not personally participate.

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

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

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

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

004.17 HOSPITAL DENTAL SERVICES. Dental care and oral surgery are effectively provided in an office setting. Dental services may be provided in a hospital or ambulatory surgical center (ASC) when the beneficiary has medical or behavioral conditions that warrant these settings to maintain beneficiary safety. ~~When dental treatment is necessary as a hospital inpatient or outpatient service, t~~These services must be provided, billed, and reimbursed in accordance with the provisions of this title ~~471 NAC 6~~.

004.18 OTHER ANCILLARY SERVICES.

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

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

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

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

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

005. NON-COVERED SERVICES. ~~The following services are not intended to be an all-inclusive, or exhaustive, list of non-covered services.~~ Non-covered services will not be covered by Nebraska Medicaid. Services will be reviewed on a case-by-case basis to determine if they are covered or not.

005.01 SURGICAL PROCEDURES. ~~The Department does not cover:~~

~~(A) Acupuncture;~~
~~(B) Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;~~
~~(C) Angiocardiography, utilizing CO_2 method, supervision and interpretation only;~~
~~(D) Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;~~
~~(E) Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;~~
~~(F) Artificial Heart Transplant;~~
~~(G) Ballistocardiogram;~~
~~(H) Basal metabolic rate (BMR);~~
~~(I) Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;~~
~~(J) Circumcision, female;~~
~~(K) Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;~~
~~(L) Extra-intra cranial arterial bypass for stroke;~~
~~(M) Fabric wrapping of abdominal aneurysm;~~
~~(N) Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;~~
~~(O) Fascia lata by stripper when used as a treatment for lower back pain;~~
~~(P) Hypogastric or presacral neurectomy (independent procedure);~~
~~(Q) Hysterotomy, non-obstetrical, vaginal;~~
~~(R) Icterus index;~~
~~(S) Ileal bypass or any other intestinal surgery for the treatment of obesity;~~
~~(T) Kidney decapsulation, unilateral and bilateral;~~
~~(U) Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;~~
~~(V) Ligation of internal mammary arteries, unilateral or bilateral;~~
~~(W) Ligation of thyroid arteries (independent procedure);~~
~~(X) Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;~~
~~(Y) Omentopexy for establishing collateral circulation in portal obstruction;~~
~~(Z) Perirenal insufflation;~~
~~(AA) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;~~
~~(BB) Protein bound iodine (PBI);~~
~~(CC) Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;~~
~~(DD) Refractive keratoplasty including keratomileusis, keratophakia, and radial keratotomy;~~
~~(EE) Reversal of tubal ligation or vasectomy;~~
~~(FF) Sex change procedures;~~
~~(GG) Splanchicectomy, unilateral or bilateral, when used as a treatment for hypertension;~~

~~(HH) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes or ovaries, one or both;~~
~~(II) Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension; and~~
~~(JJ) Uterine suspension, with or without presacral sympathectomy.~~

~~005.02 OBSOLETE TESTS. Obsolete tests may be covered only if the physician who performs the test justifies the medical necessity for the test. The Department will determine that satisfactory medical necessity exists from the physician's justification. The Department does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:~~
~~(A) Amylase, blood isoenzymes, electrophoretic;~~
~~(B) Chromium, blood;~~
~~(C) Guanase, blood;~~
~~(D) Zinc sulphate turbidity, blood;~~
~~(E) Skin test, cat scratch fever;~~
~~(F) Skin test, lymphopathia venereum;~~
~~(G) Circulation time, one test;~~
~~(H) Cephalin flocculation;~~
~~(I) Congo red, blood;~~
~~(J) Hormones, adrenocorticotropin quantitative animal tests;~~
~~(K) Hormones, adrenocorticotropin quantitative bioassay;~~
~~(L) Thymol turbidity, blood;~~
~~(M) Skin test, actinomycosis;~~
~~(N) Skin test, brucellosis;~~
~~(O) Skin test, leptospirosis;~~
~~(P) Skin test, psittacosis;~~
~~(Q) Skin test, trichinosis;~~
~~(R) Calcium, feces, 24-hour quantitative;~~
~~(S) Starch; feces, screening;~~
~~(T) Chymotrypsin, duodenal contents;~~
~~(U) Gastric analysis pepsin;~~
~~(V) Gastric analysis, tubeless;~~
~~(W) Calcium saturation clotting time;~~
~~(X) Capillary fragility test (Rumpel-Leede);~~
~~(Y) Colloidal gold;~~
~~(Z) Bendien's test for cancer and tuberculosis;~~
~~(AA) Bolen's test for cancer; and~~
~~(BB) Rehfuss test for gastric acidity.~~

005.0~~3~~1 SERVICES REQUIRED TO TREAT COMPLICATIONS OR CONDITIONS RESULTING FROM NON-COVERED SERVICES. ~~The Department may consider p~~Payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services may be made.

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

005.042(A) RELATED SERVICES. ~~The Department does not pay for a~~Associated or adjunctive services that are directly related to non-covered experimental~~/~~ or investigational services are not covered. All medically necessary expenses incurred which are not directly related to the non-covered experimental or investigative services will be paid. Complications of non-covered services may be covered once the non-covered service is completed.

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

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

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

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

(iii) The service is available only through an ~~I~~institutional ~~R~~review ~~B~~board (IRB) research protocol for the proposed use or subject to such an ~~I~~institutional ~~R~~review ~~B~~board (IRB) process; or

(iv) The service is the subject of an ongoing clinical trial(s) that meets the definition of a ~~P~~phase I, ~~P~~phase II, or ~~P~~phase III ~~C~~clinical ~~T~~trial, regardless of whether the trial is actually subject to Food and Drug Administration (FDA) oversight and regardless of whether an ~~I~~institutional ~~R~~review ~~B~~board (IRB) process or protocol is required at any one particular institution.

005.053 CUSTODIAL OR RESPITE CARE. ~~The Department does not cover h~~Hospital services that are custodial or respite care are not covered.

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

005.075 PROSTHETICS. ~~The Department does not cover e~~External powered prosthetic devices are not covered.

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

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

005.~~10~~8 HOSPITAL ACQUIRED CONDITIONS (HAC). ~~The Department will not make~~ No payment will be made for treatment of conditions that ~~which~~ are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to beneficiaries ~~patients~~. ~~This means that the Department will, at a minimum, identify as a hospital acquired conditions (HAC), those diagnoses codes that have been identified as Medicare hospital acquired conditions (HAC) when not present on hospital admission.~~ Any diagnosis code(s) which are flagged as hospital acquired will be excluded from the final claim All Patient Refined Diagnosis-Related Group (APR DRG) determination.

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

005.~~12~~09 NON-COVERED PORTABLE X-RAY SERVICES. ~~The Department does not cover t~~The following portable x-ray services are not covered:

(A) Procedures involving fluoroscopy;
(B) Procedures involving the use of contrast media;
(C) Procedures requiring the administration of a substance to the ~~patient~~ beneficiary, ~~or~~ injection of a substance into the ~~patient~~ beneficiary, or special manipulation of the beneficiary ~~patient~~;
(D) Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
(E) Procedures requiring special technical competency or special equipment or materials;
(F) Routine screening procedures; and
(G) Procedures which are not of a diagnostic nature.

006. LIMITATIONS AND REQUIREMENTS FOR CERTAIN SERVICES.

006.01 PRIOR AUTHORIZATION PROCEDURES. The physician must request prior authorization ~~for these services~~ in writing or through the appropriate electronic request ~~the standard electronic Health Care Services Review: Request for Review and Response transaction (ASC X12N 278)~~ prior to providing the service described in this chapter.

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

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

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

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

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

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

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

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

006.03 MINOR SURGICAL PROCEDURES. Reimbursement for excision of lesions of the skin or subcutaneous tissues includes all services and supplies necessary to provide the service. ~~The Department~~ Nebraska Medicaid does not make additional reimbursement for suture removal to the physician who performed the initial service or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the physician who provided the initial service, ~~the Department~~ Nebraska Medicaid may approve separate payment for the suture removal.

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

006.04(A) INTESTINAL BY-PASS SURGERY. ~~The Department does~~ This procedure is not considered ~~this procedure~~ to be reasonable and necessary and ~~does~~ it is not covered ~~the procedure~~.

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

(~~a~~1)Medically appropriate for the ~~individual~~ beneficiary; and

(~~b~~2)Performed to correct an illness which caused the obesity or was aggravated by the obesity.

006.04(B)(i) COVERAGE CONDITIONS. This procedure must be performed at a facility that is ~~a Bariatric Surgery Center of Excellence.~~ accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) or a children's hospital that has a comprehensive multidisciplinary bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and psychosocial needs of the beneficiary and family. Proof of accreditation must be submitted with each prior approval request.

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

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

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

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

006.06 STERILIZATIONS.

006.06(A) COVERAGE RESTRICTIONS. ~~Nebraska Medicaid is prohibited from paying~~ Payment for sterilization of beneficiaries is prohibited when the beneficiary is ~~individuals~~:

(i) Under the age of 21 on the date the beneficiary ~~client~~ signs the appropriate Nebraska Medicaid approved consent form ~~Form MMS-100~~; or
(ii) Legally incapable of consenting to sterilization.

006.06(B) COVERAGE CONDITIONS. ~~The Department covers s~~Sterilizations are only covered when:

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

(ii) The beneficiary ~~client~~ is advised at the outset and before the request or receipt of their consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized;
(iii) Beneficiaries ~~Clients~~ whose primary language is other than English must be provided with the required elements for informed consent in their primary language; and
(iv) Suitable arrangements must be made to communicate the required elements of informed consent to a~~n~~ beneficiary ~~individual~~ who is blind, deaf or hard of hearing, or otherwise ~~handicapped~~ disabled.

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

(1) Legally effective informed consent is obtained on the appropriate Nebraska Medicaid approved consent form ~~Form MMS-100: Consent Form~~ from the beneficiary ~~client~~ on whom the sterilization is to be performed. The surgeon must submit a properly completed and legible appropriate Nebraska Medicaid approved consent form ~~Form MMS-100~~ to ~~the Department~~ Nebraska Medicaid 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~~ one is the first day following the date on which the form is signed by the beneficiary ~~client~~. Day 31 in this period is the first day on which the procedure could be covered by ~~the Department~~ Nebraska Medicaid. The consent is effective for 180 days from the date the appropriate Nebraska Medicaid approved consent form ~~Form MMS-100~~ is signed.

006.06(C)(i) EXCEPTION. A~~n~~ ~~individual~~ beneficiary may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since the beneficiary ~~he or she~~ signed the informed consent for the sterilization. For a premature delivery, the beneficiary ~~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 the appropriate Nebraska Medicaid approved consent form ~~Form MMS-100~~.

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

(a) A clear explanation of the procedures to be followed;
(b) A description of the attendant discomforts and risks that may follow the procedure, including an explanation of the type and possible effects of an anesthetic to be used;
(c) A description of the benefits to be expected;
(d) Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;
(e) An offer to answer any questions concerning the procedures; ~~and~~
(f) An instruction that the beneficiary ~~individual~~ is free to withhold or withdraw their consent to the sterilization at any time before the sterilization without prejudicing ~~their~~ future care and without loss of other project or program benefits to which the beneficiary ~~client~~ might otherwise be entitled;
(g) Advice that the sterilization will not be performed for at least 30 days, except under ~~the~~ circumstances previously specified ~~circumstances~~; and

(h) The ~~individual~~ beneficiary to be sterilized must be permitted to have a witness of her or his choice present when informed consent was obtained.

006.06(C)(ii)(1) ~~CLIENT~~ BENEFICIARY RESPONSIBILITY. The~~is~~ required informed consent information is shown on the appropriate Nebraska Medicaid approved consent form ~~Form MMS-100~~, which must be completed by the beneficiary ~~client~~.

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

(i) The ~~person~~ provider who secured authorization to perform the hysterectomy has informed the ~~individual~~ woman and her representative, if any, orally and in writing, that the hysterectomy will make the ~~individual~~ woman permanently incapable of reproducing; and

(ii) The ~~individual~~ woman or her representative, if any, has signed the appropriate Nebraska Medicaid approved consent form ~~Form MMS-101~~ acknowledging receipt of that information.

006.07(A) EXCEPTION. ~~The Department does not require i~~Informed consent is not required if:

(1) The ~~individual~~ woman was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the ~~individual~~ woman was already sterile before the hysterectomy and states the cause of the sterility;~~.~~

(2) In the case of a post-menopausal woman, ~~the Department~~ Nebraska Medicaid considers the woman to be sterile. All claims related to the procedure must indicate that the woman ~~client~~ is post-menopausal; or~~.~~

(3) The ~~individual~~ woman requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that informed consent ~~prior acknowledgment~~ is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the ~~patient~~ physician determined informed consent ~~prior acknowledgment~~ was not possible. The physician must also include certification of the emergency.

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

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

(i) It was performed solely to make the woman sterile; or

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

006.08 ABORTIONS. ~~The Department covers a~~Abortions are covered when the life of the mother would be endangered if the fetus were carried to term for which federal financial participation is currently available under ~~Title XIX of the Social Security Act~~ federal regulations and the Nebraska Medicaid State Plan. A physician must certify the diagnosis by medical reports which include the name and address of the mother ~~client~~. The treating physician must request and receive prior authorization from Nebraska Medicaid before providing the service ~~from the Department before providing the service~~. If approved, ~~the Department will send~~ a letter of authorization will be sent to the provider ~~and retains one copy of the letter of authorization~~. In cases of documented emergencies, authorization may be requested after the service has been provided. All other requirements of this subsection must be met.

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

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

006.10(A) PHYSICIANS' SERVICES. ~~The Department covers r~~Routine prenatal care, delivery, ~~six weeks~~ post-partum care, and routine urinalysis are covered as a package service for physicians in accordance with this title ~~471 NAC 18~~. ~~The Department does not reimburse h~~Hospitals will not be reimbursed for any physicians' services included in the package service.

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

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

006.11 ALCOHOL AND CHEMICAL DETOXIFICATION. ~~The Department limits p~~Payment for alcohol and chemical detoxification is limited to medically necessary treatment, subject to ~~the Department's~~ Nebraska Medicaid's utilization review (UR). This coverage period includes ~~an average detoxification period of two to three days with an occasional need for~~ up to five days ~~when~~ as the ~~patient's~~ beneficiary's condition dictates. A detoxification program for a particular ~~patient~~ beneficiary may exceed five days and be covered if determined medically necessary by ~~the Department~~ Nebraska Medicaid. ~~The Department does not cover s~~Services

when the detoxification needs of a~~n~~ ~~individual~~ beneficiary no longer require an inpatient hospital setting are not covered.

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

006.12(A) INVASIVE OSTEOGENIC STIMULATION. ~~Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. For percutaneously placed cathodes, the power supply is externally placed and the leads connected to the inserted cathodes. For the implanted cathode, the power pack is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. The Department covers u~~Use of the invasive device is covered only for non-union of long bone fractures. ~~The Department considers n~~Non-union is considered to exist only after six months or more have elapsed without the fracture healing.

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

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

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

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

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

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

006.15 THERAPEUTIC SERVICES. ~~The Department may cover t~~Therapeutic services may be covered provided they are standard and accepted services, and are reasonable and medically necessary for the ~~patient~~ beneficiary. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services will be provided for:

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

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

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

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

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

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

006.16(B)(ii) COVERAGE LIMIT. Coverage is limited to 12 weeks ~~(~~or 36 sessions~~)~~ of a monitored exercise program. For coverage beyond a maximum duration of 12 weeks ~~(~~or 36 sessions~~)~~, the provider must submit documentation supporting the ~~patient's~~ beneficiary's need for additional services. Documentation must include:

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

006.17 MEDICAL TRANSPLANTS. ~~The Department covers t~~Transplants including donor services that are medically necessary and defined as non-experimental by Medicare are covered. If no Medicare policy exists for a specific type of transplant, ~~the Department~~ it will be determined whether the transplant is medically necessary or non-experimental. ~~The Department will cover t~~Transplantation services are covered when performed in a facility approved by Centers for Medicare ~~Medicaid and~~ & Medicaid~~are~~ Services (CMS) as meeting coverage criteria.

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

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

006.17(B) SERVICES FOR A NEBRASKA MEDICAID-ELIGIBLE DONOR. ~~The Department covers m~~Medically necessary services, including laboratory tests directly

related to the transplant are covered, for the Nebraska Medicaid-eligible donor to a Nebraska Medicaid-eligible beneficiary ~~client~~. The services must be directly related to the transplant.

006.17(C) SERVICES FOR A NEBRASKA MEDICAID-INELIGIBLE DONOR. ~~The Department covers m~~Medically necessary services, including laboratory tests directly related to the transplant, for the Nebraska Medicaid-ineligible donor to a Nebraska Medicaid-eligible beneficiary are covered ~~client~~. The services must be directly related to the transplant and must directly benefit the Nebraska Medicaid transplant beneficiary ~~client~~. Coverage of treatment for complications related to the donor is limited to those that are reasonably medically foreseeable. Claims must be submitted under the Nebraska Medicaid-eligible beneficiary's ~~client's~~ case number.

006.17(D) ADDITIONAL RECORDS REQUEST. ~~The Department~~ Nebraska Medicaid reserves the right to request any medical documentation from the ~~patient's~~ beneficiary's record to support and substantiate claims submitted for payment.

006.17(E) PAYOR OF LAST RESORT. ~~The Department~~ Nebraska Medicaid is the payor of last resort.

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

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

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

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

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

006.19(A) BILLING TECHNICAL COMPONENT. The hospital room charge is considered the technical component of the visit and must be billed on the appropriate Nebraska Medicaid approved claim form ~~Form CMS-1450 (UB-92)~~.

006.20 INFANT APNEA MONITORS. ~~The Department covers r~~Rental of home infant apnea monitors for infants with medical conditions that require monitoring due to a specific medical

diagnosis is covered only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent~~/~~ or caregiver training must occur before placement of infant apnea monitor. Parent~~/~~ or caregiver training is not reimbursed as a service separate from infant apnea monitor rental.

006.20(A) MEDICAL GUIDELINES FOR THE PLACEMENT OF HOME INFANT APNEA MONITORS. ~~The Department covers h~~Home infant apnea monitoring services for infants, defined as birth through completion of one year of age, who meet one of the following criteria are covered according to criteria under this title.~~:~~

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

~~(ii) Symptomatic preterm infants;~~

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

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

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

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

(i) The number of apnea episodes during the previous prescription period;
(ii) The results of any tests performed during the previous prescription period;
(iii) Additional length of time needed; and
(iv) Any additional information the physician may wish to provide.

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

006.20(E) COVERED AND NON-COVERED COMPONENTS. ~~The Department does not cover m~~Monitors that do not use rechargeable batteries are not covered. ~~The Department~~

~~does not make s~~Separate payment for remote alarms will not be made. If provided, payment for a remote alarm is included in the monitor rental. Apnea monitor belts, lead wires, and reusable electrodes are covered for rented apnea monitors.

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

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

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

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

006.21(A)(i) HOME PHOTOTHERAPY REQUIREMENTS. 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, complete blood count (CBC), blood type on mother and infant, direct Coombs test, direct and indirect bilirubin;
(3) The physician certifies that the parent or caregiver is capable of administering home phototherapy;
(4) Parent or caregiver have successfully completed training on use of the equipment; and
(5) Equipment must be delivered and set up within 4 four hours of discharge from the hospital or notification of provider, whichever is more appropriate. There must be a 24-hour per day repair or replacement service available.

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

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

~~(i) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;~~

~~(ii) A minimum of one daily visit to the home by a licensed or certified "health care professional" as identified by the supplier in the "Coordination Plan." The daily visits must include:~~

~~(1) A brief home assessment; and~~

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

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

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

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

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

(i) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;

(ii) A minimum of one daily visit to the home by a licensed or certified ~~"~~health care professional~~"~~ is required. The daily visits must include:

(1) A brief home assessment; and

(2) Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available. An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill Nebraska 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; and

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

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

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

(1) An overview of the services provided, including the provider's charge for the services;

(2) Descriptions and literature on the equipment and all supplies and accessories provided;

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

006.22(A) CHANGES TO COORDINATION PLAN. The provider must notify ~~the Department~~ Nebraska Medicaid of any changes in the coordination plan. After review of the coordination plan, the provider may be required to amend the coordination plan.

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

006.23 AMBULATORY ROOM AND BOARD. ~~The Department covers a~~Ambulatory room and board is covered as a related transportation and as follows:

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

006.23(A)(i) PROVIDER RE-APPROVAL. Each hospital approved by ~~the Department~~ Nebraska Medicaid to provide ambulatory room and board services must seek re-approval of its ambulatory room and board services from ~~the Department~~ Nebraska Medicaid when any of the following occur:
(1) The charge to ~~the Department~~ Nebraska Medicaid 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 beneficiaries ~~clients~~ in the ambulatory room and board facility; or
(4) Other substantial changes are made to the hospital's ambulatory room and board services.

006.23(B) GUIDELINES. ~~The Department covers a~~Ambulatory room and board services are covered when travel is necessary to seek medical care. Coverage of ambulatory room and board must meet the following guidelines ~~as follows~~:
(1) ~~Ambulatory room and board~~ The services must be necessary to secure Nebraska Medicaid coverable services, including medical examinations or treatment~~.~~;
(2) ~~The Department covers m~~Meals are covered when receipt of Nebraska Medicaid coverable services requires the beneficiary ~~client~~ to be away from their home for 12 hours or longer;

(3) ~~The Department covers lodging when a~~An out-of-town overnight stay is necessary while receiving Nebraska Medicaid coverable services or if coverage of ambulatory room and board services will prevent a hospital inpatient stay; ~~and~~

(4) ~~The Department covers m~~Meals and lodging for up to one day before or after receiving services if extensive travel is necessary~~.~~; and

(5) ~~The Department covers u~~Up to one person who accompanies the beneficiary ~~client~~ when the beneficiary ~~client~~ is physically or mental unable to travel or wait alone. ~~For example, a child's parent or guardian.~~

006.23(B)(i) ADDITIONAL REQUIREMENT. Payment for ambulatory room and board services outside these ~~guidelines~~ requirements must be approved Nebraska Medicaid ~~by the Department staff~~.

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

006.23(D) BILLING AND PAYMENT. The hospital must bill for ambulatory room and board services provided by a ~~Department~~ Nebraska Medicaid enrolled hospital as an outpatient service on the appropriate claim form or electronic format and the appropriate Healthcare Common Procedure Coding System (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.

007. BILLING AND PAYMENT FOR HOSPITAL SERVICES.

007.01 PAYMENT.

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

007.01(B) SPECIFIC PAYMENT REQUIREMENTS.

007.01(B)(i) OUTPATIENT SERVICES. ~~The Department provides r~~Reimbursement for hospital outpatient services provided to Nebraska Medicaid eligible beneficiaries ~~clients~~ will be provided on a prospective basis in accordance with the rate methodology for ~~O~~outpatient ~~H~~hospital and ~~E~~emergency ~~R~~room ~~S~~services. Reimbursement for the following services is included in the prospective rate payment for hospital inpatient services:

(1~~a~~)Technical ~~C~~component of ~~H~~hospital ~~O~~outpatient ~~R~~radiology ~~S~~services;

(2~~b~~)Non-~~P~~patient ~~R~~radiology ~~S~~services;

(3~~c~~)Anesthesiology:

(a~~i~~)Technical ~~C~~component of ~~M~~medical ~~D~~direction of ~~F~~four or ~~F~~fewer ~~C~~concurrent ~~P~~procedures for hospital outpatient;

(b~~ii~~)Technical component of outpatient anesthesiology services provided by anesthetists who are not employees of a physician; ~~and~~

(4~~d~~)Medical ~~T~~transplants, hospital charges for ambulatory stays~~.~~; and

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

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

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

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

(1~~a~~)Hospital observation services when the beneficiary ~~client~~ is thereafter admitted as an inpatient of the same hospital;

(2~~b~~)Hospital outpatient or emergency room services when the beneficiary ~~client~~ is thereafter admitted as an inpatient of the same hospital before midnight of the same day;

(3~~c~~)Non-physician inpatient services and ~~i~~items:

(a~~i~~)Outpatient and emergency room services provided by the hospital before admission; ~~and~~

(b~~ii~~)Outpatient or inpatient services provided by another hospital or free-standing medical facility to an inpatient of the original admitting facility~~.~~; and

(c~~iii~~)Payment for durable medical equipment, orthotics, and prosthetics~~, etc.,~~ for hospital inpatients ~~is included in the hospital's payment for inpatient services~~;

(4~~d~~)Labor and delivery~~: The Department utilizes~~ utilizing the current Medicare methodology is utilized in accounting for labor and delivery charges on the Medicare cost report;

(5~~e~~)Technical component of inpatient clinical laboratory services~~: The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate~~;

(6~~f~~)Technical component of inpatient anatomical pathology services~~: The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate~~;

(7~~g~~)Technical component of hospital inpatient radiology services~~: These costs may be included on the hospital's cost report to be considered in calculating the hospital's payment rate~~;

(8~~h~~)Anesthesiology:

(a~~i~~)Technical component of medical direction of four or fewer concurrent procedures for hospital; and

(b~~ii~~)Technical component of inpatient anesthesiology services provided by anesthetists who are not employees of a physician;

(9~~i~~)Inpatient dialysis~~: The hospital may include the costs of inpatient dialysis services on it cost report to be considered in calculation the hospital payment rate.~~;

(10j)Pre-Admission Testing;
(11k)Medical transplants:
(ai)Hospital inpatient services, including procurement costs; and
(bii)Technical component of inpatient laboratory and diagnostic and therapeutic radiology;
(12l)Infant apnea monitoring services provided to an inpatient.;
(13) Services which are included by a hospital in the Medicare cost report; and
(14) Services which are customarily reimbursed as a part of the prospective payment for inpatient services.

007.01(B)(ii)(1) This list is not intended to be an exclusive list of services that are reimbursed as a part of the hospital prospective payment for inpatient services. Other services that are considered to be included within the scope of services that are reimbursed as a part of the prospective payment for inpatient services include, but are not limited to, the following:
(a) Services which are included by a hospital in the Medicare cost report; or
(b) Services which are customarily reimbursed as a part of the prospective payment for inpatient services.

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

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

007.01(B)(v)(iii) INPATIENT ADMISSION AFTER OUTPATIENT SERVICES. A patient beneficiary may be admitted to the hospital as an inpatient after receiving hospital outpatient services. Inpatient services, for billing and payment purposes, includes the following:
(1a)Non-physician outpatient services rendered on the day of admission or during the inpatient stay;
(2b)Diagnostic services rendered up to three days before the day of admission; and
(3c)Admission related non-diagnostic services rendered up to 3 three days before the day of admission. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

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

007.01(B)(vi) INTERIM PAYMENT FOR LONG-STAY PATIENTS. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days. To request an interim payment, the hospital must send the appropriate claim form or electronic format to the

~~Department indicating the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days.~~

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

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

007.01(B)~~(viii)~~(iv) NON-PAYMENT FOR HOSPITAL ACQUIRED CONDITIONS. ~~The Department will not make p~~Payment will be made for those claims which are identified as non-payable by ~~Medicare~~ the All-Patient Refined Diagnosis-Related Group (APR DRG) as a result of avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to ~~patients~~ beneficiaries. ~~This provision applies only to those claims in which the Department is a secondary payor to Medicare.~~

~~007.01(B)(ix) OUT-OF-PLAN SERVICES. When Managed Care enrollees are provided hospital inpatient services by Nebraska Medicaid enrolled facilities not under contract with the Department's managed care organizations (MCO), the managed care organizations (MCO) are authorized, but are not required, to pay for the care provided at rates the Department would otherwise reimburse providers.~~
~~007.01(B)(x) LOWER LEVELS OF CARE. When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. Medically necessary skilled nursing care must be authorized within 15 days of admission.~~

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

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

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

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

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

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

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

007.01(D) PAYMENT FOR SERVICES FURNISHED BY A CRITICAL ACCESS HOSPITAL (CAH). Items and services that a critical access hospital (CAH) provides to its inpatients are covered if they are items and services that would be covered if furnished for hospital-to-hospital inpatients, subject to the 96-hour average on inpatient stays in critical access hospitals. ~~The Department reimburses t~~The reasonable cost of providing the services is reimbursed, as determined under applicable Medicare principles of reimbursement., ~~except that t~~The following Medicare principles of reimbursement do not apply:

(i) The lesser of costs or charges (LCC) rule;
(ii) Ceilings on hospital operating costs; and
(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers.

~~the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers. Subject to the 96-hour average on inpatient stays in critical access hospitals (CAH), items and services that a critical access hospital (CAH) provides to its inpatients are covered if~~

they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

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

(i) The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for Nebraska Medicaid. This requirement does not apply to a hospital:

(1) The inpatients of which are predominantly individuals under 18 years of age; or

(2) Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.

(3) For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

(ii) Only Nebraska hospitals which have a current enrollment with Nebraska Medicaid will be considered for eligibility as a Disproportionate Share Hospital.

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

007.01(F)(i) RECAPTURE OF DEPRECIATION. A hospital which is sold for a profit and has received Nebraska Medicaid payments for depreciation must refund to the Department the lower of:

(1) The amount of depreciation allowed and paid by the Department; or

(2) The product of:

(a) The ratio of Nebraska Medicaid allowed inpatient days to total inpatient days; and

(b) The amount of gain on the sale as determined by the Medicare.

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

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

007.01(G)(i) REQUEST FOR RATE ADJUSTMENTS. Hospitals may submit a request to the Department for an adjustment to their rates for the following:

(1) An error in the calculation of the rate;

(2) Extraordinary circumstances. Extraordinary circumstances are limited to:

(a) Changes in routine and ancillary costs, which are limited to:

~~(i) Intern and resident related medical education costs; and~~
~~(ii) Establishment of a subspecialty care unit;~~
~~(b) Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase; or~~
~~(3) Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:~~
~~(a) One-time occurrence;~~
~~(b) Less than twelve-month duration;~~
~~(c) Could not have been reasonably predicted;~~
~~(d) Not of an insurable nature;~~
~~(e) Not covered by federal or state disaster relief; and~~
~~(f) Not a result of malpractice or negligence.~~

~~007.01(G)(ii) ADJUSTMENT CONDITIONS. In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital. If an adjustment is granted, the peer group rates will not be changed. In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital must demonstrate the following:~~
~~(1) Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control.~~
~~(2) Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.~~
~~(3) The rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.~~

007.07~~(H)~~1(E) ACCESS TO RECORDS. Hospitals must make all records relating to the care of Nebraska Medicaid ~~patients~~ beneficiaries and any and all other cost information available to ~~the Department~~ Nebraska Medicaid, its designated representatives or agents, or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

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

~~007.01(J) COST REPORT AUDITS. The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.~~

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

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

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

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

~~(i) The provider's submitted charge; or~~

~~(ii) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service.~~

007.01~~(N)~~(F) 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 is approved:

(1) The ~~patient~~ beneficiary is evaluated or treated for an emergency medical condition;

(2) The ~~patient's~~ beneficiary'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~~ beneficiary is referred by his or her physician for treatment in an emergency room.

007.01~~(N)~~(F)(i) NON-EMERGENT SERVICES. When the facility or ~~the Department~~ Nebraska Medicaid determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of

what would otherwise be allowed. All other Nebraska Medicaid allowable charges incurred in this type of visit will be paid according to this chapter ~~471 NAC 10~~.

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

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

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

007.01~~(S)~~(G) LIMITATIONS ON PAYMENT FOR HOSPITAL SERVICES.

007.01~~(S)~~(G)(i) PLACE OF SERVICE. ~~The department may review, reduce, or deny p~~Payment for covered outpatient or emergency room drugs, supplies, or services which could have been provided in a less expensive setting may be reviewed, reduced, or denied.

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

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

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

~~007.01(T) THE DEPARTMENT SURVEILLANCE AND UTILIZATION REVIEW OF HOSPITAL SERVICES. The Department or its designee, reviews hospital inpatient services for:~~

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

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

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

~~007.01(T)(i)(1) REVIEW FOR ALL SELECTED CASES. Validation will include:~~
~~(a) Validation of diagnostic and procedural information and ICD-9-CM coding;~~
~~(b) Medical necessity for inpatient admission and procedure(s);~~
~~(c) Stability at discharge; and~~
~~(d) Quality of care.~~

007.01~~(T)~~(H)(i)(~~2~~1) PAYMENT REDUCTION. If ~~the Department~~ Nebraska Medicaid, or its designee, determines that either admissions or discharges are performed without medical justification, payment for inpatient services may be denied. Payment can be reduced if coding inaccuracies are identified by ~~the Department~~ Nebraska Medicaid or its designee. Any cost outlier which is not determined to be medically necessary for hospital inpatient care by ~~the Department~~ Nebraska Medicaid, or its designee may qualify for payment as a lower level of care (LOC) payment.

007.01~~(T)~~(H)(ii) REVIEW ACTIVITIES FOR HOSPITAL INPATIENT SERVICES REIMBURSED ON A PROSPECTIVE PER DIEM BASIS. Hospital inpatient care must be reasonable, medically necessary, and appropriate for the class of care being billed. All hospital inpatient admissions must be certified by ~~the Department~~ Nebraska Medicaid 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~~ Nebraska Medicaid or its designee determines the service was not medically necessary. ~~The Department~~ Nebraska Medicaid 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 (LOC) according to this chapter ~~471 NAC 10~~ or denied.

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

007.02 BILLING.

007.02(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in this title ~~471 NAC 3~~. ~~In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this 471 NAC 10, the individual billing requirements in 471 NAC 10 must govern.~~

007.02(B) SPECIFIC BILLING REQUIREMENTS. Providers of hospital services must submit claims to ~~the Department~~ Nebraska Medicaid on the appropriate Nebraska Medicaid approved claims form ~~Form CMS-1450~~.

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

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

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

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

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

(i) Diagnostic-related group (DRG) payment method, the Department does not make additional payments are not made for complications and comorbidities, (CC) and major complications and comorbidities (MCC).

(ii) Cost-to-~~C~~charges (CCR) payment method, ~~the Department does not pay for~~ charges attributable to the hospital-acquired conditions (HAC) are not paid.

(iii) Per ~~D~~diem payment method, ~~the Department will limit~~ provider payment reductions are limited to the extent that the identified provider-preventable condition (PPC) would otherwise result in an increase in payment, or if ~~the Department can reasonably isolate for nonpayment~~ the portion of the

payment directly related to the provider-preventable condition (PPC) can be reasonably isolated for nonpayment.

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

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

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

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

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

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

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

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

(i) A doctor of medicine or osteopathy;
(ii) A doctor of dental surgery or dental medicine;
(iii) A doctor of podiatric medicine;
(iv) A doctor of optometry; ~~or~~
(v) An advanced practice registered nurse (APRN); or
(vi) A chiropractor.

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

(i) Admissions to the hospital;

(ii) The duration of stays; and
(iii) Professional services provided, including drugs.

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

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

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

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

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

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

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

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

007.02(B)(vii)(4) RECERTIFICATION OF CONTINUED STAY. ~~Recertification must be made at least every 60 days after initial certification. Psychiatric inpatient care must be certified every 30 days.~~ A beneficiary's first recertification is required no later than the 12th day of continued hospitalization. Subsequent recertifications are required at least every 30 days.

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

007.02(B)(ix) SWING BEDS. ~~The Department covers swing beds only for skilled nursing care where a client requires 24-hour professional nursing care.~~ A per diem that includes post-hospital 24-hour skilled nursing care services that must be provided by or under the direct supervision of professional or technical personnel and requires skilled knowledge, judgment, observation, and assessment will be paid. This per diem payment includes all items and services aside from ancillary services and therapies. Prior authorization for admission to a swing bed is required by Nebraska Medicaid.

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

~~(a) Complete an admission Form MC-9-NF or use the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);~~

~~(b) Submit a copy of Form DM-5 or physician's history and physical;~~

~~(c) Complete Long Term Care Evaluation; and~~

~~(d) Submit all the information to the local office.~~

007.02(B)(x) ANCILLARY SERVICES AND THERAPIES. The hospital must bill for ancillary services for swing-bed ~~patients~~ beneficiaries who are eligible for Nebraska Medicaid only. If Medicare is covering the swing-bed services, the facility must not bill ~~the Department~~ Nebraska Medicaid for ancillary services. Laboratory, radiology, respiratory therapy, physical therapy (PT), occupational therapy (OT), speech-language pathology, and audiology services must be billed on the outpatient claim form or in electronic format as outpatient services. Payments for therapies must be reported on the Medicare cost report as outpatient revenues.

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

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

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

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

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

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

008.01(D) BENEFICIARY MEDICAL RECORDS. If a beneficiary is seeking to be considered by a Medicaid program, medical records must be provided to them at no cost.

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

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

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

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 46 RATES FOR HOSPITAL SERVICES

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

002. DEFINITIONS. The following definitions apply:

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

002.02 ALL-PATIENT REFINED DIAGNOSIS-RELATED GROUP (APR DRG). The All-Patient Refined Diagnosis-Related Group grouper (APR DRG) is a software application that assigns patients into categories based on severity of illness and risk of mortality. ~~A diagnosis related group classification system.~~

002.03 ANCILLARY SERVICES. Ancillary services are supportive or diagnostic measures that supplement and support a primary physician, nurse, or other healthcare provider in treating a patient.

002.0~~3~~4 BASE YEAR. The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

002.0~~4~~5 BUDGET NEUTRALITY. Payment rates are adjusted for budget neutrality such that estimated expenditures for the current rate year are not greater than expenditures for the previous rate year, trended forward.

002.0~~5~~6 CAPITAL-RELATED COSTS. Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

002.0~~6~~7 CASE-MIX INDEX. An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

002.0~~7~~8 COST OUTLIER. Cases which have an extraordinarily high cost as established in this chapter ~~so as~~ to be eligible for additional payments above and beyond the initial diagnosis-related group payment.

002.0~~8~~9 CRITICAL ACCESS HOSPITAL (CAH). A hospital licensed as a critical access hospital (CAH) by the Department of Health and Human Services, Division of Public Health, and certified for participation by Medicare as a critical access hospital (CAH).

002.1~~0~~9 DIAGNOSIS-RELATED GROUP (DRG). A group of similar diagnoses combined based on patient age, birth weight, procedure coding, comorbidity, and complications.

002.1~~1~~0 DIRECT MEDICAL EDUCATION (DME) COST PAYMENT. An add-on to the operating cost payment amount to compensate for direct medical education (DME) costs associated with approved intern and resident programs. ~~Costs associated with direct medical~~

~~education are determined from the hospital base year cost reports and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.~~

002.12~~1~~ DISPROPORTIONATE SHARE HOSPITAL (DSH). A hospital located in Nebraska is deemed to be a disproportionate share hospital (DSH) by having:

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

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

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

002.14~~2~~ DISTINCT PART UNIT. A Medicare-certified hospital-based substance ~~abuse~~ use disorder, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

002.15~~4~~ 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 Nebraska Medicaid provider number.

002.16~~5~~ HOSPITAL-SPECIFIC BASE YEAR OPERATING COST. Hospital-specific operating allowable cost associated with treating Nebraska Medicaid beneficiaries ~~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 (DME) costs, ~~and~~ indirect medical education (IME) costs, and graduate medical education costs.

002.17~~6~~ HOSPITAL-SPECIFIC COST-TO-CHARGE RATIO (CCR). Hospital-specific cost-to-charge ratio (CCR) is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-specific cost-to-charge ratios (CCR) used for outlier cost payments and transplant diagnosis-related group cost-to-charge ratio~~s~~ (CCR) payments are derived from the outlier cost-to-charge ratios (CCR) in the Medicare inpatient prospective payment system.

002.18 HOSPITAL QUALITY ASSURANCE AND ACCESS ASSESSMENT. A quality assurance and access assessment imposed on hospitals as defined in these regulations. The hospital quality assurance and access assessment shall be used to fund the non-federal share of hospital directed payments throughout the statutory period allowed by law.

002.19~~17~~ INDIRECT MEDICAL EDUCATION (IME) 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 (DME) cost payments.

002.20 LONG-TERM ACUTE CARE HOSPITAL (LTACH). A hospital that is licensed as a general acute care hospital that focuses on treating patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. Patients treated in a long-term acute care hospital (LTACH) are not generally appropriate for lower level of care (LOC) settings, but are expected to improve to lower level of care (LOC) status.

002.2118 LOW-INCOME UTILIZATION RATE. For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum of the fractions, expressed as a percentage, ~~of the fractions,~~ calculated from acceptable data submitted by the hospital as follows:

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

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

002.2219 NEBRASKA MEDICAID ALLOWABLE INPATIENT CHARGES. The ~~T~~total claim submitted charges less claim non-allowable amount.

002.2320 NEBRASKA MEDICAID ALLOWABLE INPATIENT DAYS. The total number of covered Nebraska Medicaid inpatient days.

002.2421 NEBRASKA MEDICAID INPATIENT UTILIZATION RATE. The ratio of allowable Nebraska Medicaid inpatient days, as determined by Nebraska Medicaid, to total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Nebraska 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~~ Nebraska Medicaid prior to the beginning of the Nebraska Medicaid rate period.

002.2522 NEBRASKA MEDICAID RATE PERIOD. The period of July 1 through the following June 30.

002.2623 MEDICAL REVIEW. Review of Nebraska Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay~~,~~; completeness~~,~~; adequacy~~,~~; and quality of care; appropriateness of admission~~,~~; discharge and transfer; and appropriateness of prospective payment outlier cases.

002.2724 MEDICARE COST REPORT. The report filed by each facility with its Medicare fiscal intermediary. A hospital that does not participate in the Medicare program will complete the Medicare cost report in compliance with Medicare principles and supporting rules, regulations, and statutes. The hospital will file the completed form with Nebraska Medicaid

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 Nebraska Medicaid or its designees. If a nursing facility is affiliated with the hospital, the nursing facility cost report must be filed as outlined in these regulations.

002.2825 NATIONAL WEIGHTS. The 3M ~~APR-DRG~~ All-Patient Refined Diagnosis-Related Group grouper (APR DRG) National Weights are calculated using the Nationwide Inpatient Sample released by the Healthcare Cost and Utilization Project. ~~A hospital that does not participate in the Medicare program shall complete the Medicare Cost Report in compliance with Medicare principles and supporting rules, regulations, and statutes. The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees. If a nursing facility is affiliated with the hospital, the nursing facility cost report must be filed according to this chapter. Note specifically that time guidelines for filing nursing facility cost reports differ from those for hospitals.~~

002.2926 NEW OPERATIONAL FACILITY. 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. A new operating facility provides~~ing~~ inpatient hospital care ~~which~~ that meets one of the following criteria:

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

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

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

002.30 NON-ACUTE ADMIN DAYS. Nebraska Medicaid coverage for hospital care when a Nebraska Medicaid beneficiary, who is an inpatient, no longer requires acute inpatient care and requires nursing facility level of care (LOC) upon discharge but is unable to be transferred to a nursing facility due to a lack of available nursing facility beds, or in cases when the transfer requires a guardian, and a guardian has not been appointed.

002.3127 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 (DME) costs, ~~and~~ indirect medical education (IME) costs, and graduate medical educations costs.

002.3228 PEER GROUP. A grouping of hospitals or distinct part units ~~with similar characteristics~~ of a hospital for the purpose of determining payment amounts. Hospitals are grouped with similar characteristics, licenses, Medicare certification, and classifications in the Centers for Medicare & Medicaid Services (CMS) inpatient prospective payment system impact file. Hospitals are classified into the following ~~one of six p~~Peer ~~g~~Groups:

(A) Peer Group 1: Metro Acute Care Hospitals;

(B) Peer Group 2: Urban Acute Care & Regional Rural Referral Hospitals;

(C) Peer Group 3: Rural Acute Care Hospitals;
(D) Peer Group 4: Indian Health Service (HIS) & Beatrice Development Center (BSDC) Hospitals;
(E) Peer Group 5: Mental Health and Psychiatric Inpatient Hospitals;
(F) Peer Group 6: Physical Rehabilitation Hospitals;
(G) Peer Group 7: Critical Access Hospitals (CAH);
(H) Peer Group 8: Rural Emergency Hospitals;
(I) Peer Group 9: Long-Term Acute Care Hospitals (LTACH); or
(J) Peer Group 10: Children's Hospitals.
~~(A) Metro acute care hospitals: Peer Group 1: Hospitals located in metropolitan statistical areas as designated by Medicare;~~
~~(B) Other urban acute care hospitals: Peer Group 2: Hospitals that have been redesignated to a metropolitan statistical area by Medicare for federal fiscal year 1995 or 1996 or hospitals designated by Medicare as regional rural referral centers;~~
~~(C) Rural acute care hospitals: Peer Group 3: All other acute care hospitals;~~
~~(D) Psychiatric hospitals and distinct part units in acute care hospitals: Peer Group 4: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;~~
~~(E) Rehabilitation hospitals and distinct part units in acute care hospitals: Peer Group 5: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and~~
~~(F) Critical access hospital: Peer Group 5: Hospitals that are certified as critical access hospitals by Medicare.~~

002.33~~29~~ PEER GROUP BASE PAYMENT AMOUNT. A base payment per discharge or per diem amount used to calculate the operating cost payment amount. ~~The base payment amount is the same for all hospitals in a peer group except Peer Group 1, Children's Hospitals, Peer Group 5 and Peer Group 6.~~ The hospitals in Peer Group 1 Metro Acute Care Hospitals, Peer Group 2 Urban & Regional Rural Referral Hospitals, Peer Group 3 Rural Acute Care Hospitals, Peer Group 5 Mental Health and Psychiatric Inpatient Hospitals, Peer Group 9 Long-Term Acute Care Hospitals (LTACH), and Peer Group 10 Children's Hospitals will have the same base payment or per diem amount.

002.34~~30~~ REPORTING PERIOD. Same reporting period as that used for ~~it's~~ the Medicare cost report.

002.35~~31~~ RESOURCE INTENSITY. The relative volume and types of diagnostic, therapeutic, and bed services used in the management of a particular disease.

002.36~~32~~ RISK OF MORTALITY (ROM). The likelihood of dying.

002.37 RURAL EMERGENCY HOSPITAL. A hospital licensed as a rural emergency hospital by the Department of Health and Human Services, Division of Public Health, and certified for participation by Medicare as a rural emergency hospital. A rural emergency hospital solely provides outpatient services, including emergency department services, observation care, and additional outpatient medical and health services that do not exceed an annual per patient length of stay of 24 hours on average.

002.38~~33~~ SEVERITY OF ILLNESS LEVEL ~~(SOI)~~. The extent of physiologic decompensation or organ system loss of function.

002.39 SWING BED. Post-hospital 24-hour skilled nursing care services that must be provided by or under the direct supervision of professional or technical personnel and requires skilled knowledge, judgment observation, and assessment.

002.4034 TAX-RELATED COSTS. Any real or personal property tax, sales tax, excise tax, tax enacted pursuant to federal public laws, ~~the Medicaid Voluntary Contribution Provider Specific Tax Amendment of 1991 (P.L. 102-234)~~ or any amendments thereto, franchise fee, license fee, or hospital-specific tax, fee or assessment imposed by the local, state, or federal government, but not including income taxes.

002.41 TRANSPLANT DIAGNOSIS-RELATED GROUPS (DRG). Transplant diagnosis-related groups (DRG) are identified in the All-Patient Refined Diagnosis-Related Group grouper (APR DRG). Nebraska Medicaid does not recognize bone marrow transplant diagnosis-related groups in its classification with all other transplant diagnosis-related groups categorized by the All-Patient Refined Diagnosis-Related Group grouper (APR DRG). Bone marrow transplant diagnosis-related groups do not receive a transplant cost-to-charge ratio (CCR) or transplant direct medical education (DME) payment. The bone marrow transplant diagnosis-related groups per discharge payment is the sum of the operating cost payment amount, the capital-related cost payment, and when applicable a direct medical education (DME) cost payment, indirect medical education (IME) cost payment, and a cost outlier payment.

002.4235 UNCOMPENSATED CARE. Uncompensated care includes the difference between costs incurred and payments received in providing services to Nebraska Medicaid ~~patients~~ beneficiaries and uninsured.

003. PAYMENT FOR PEER GROUPS ~~1, 2, AND 3 METRO ACUTE, OTHER URBAN ACUTE, AND RURAL ACUTE~~ 1 METRO, 2 URBAN AND REGIONAL RURAL REFERRAL, 3 RURAL, AND 10 CHILDREN'S. Payments for inpatient acute care services are made on a prospective per discharge basis~~, except hospitals certified as a critical access hospital~~. For inpatient services that are classified into a diagnosis-related group, the total per discharge payment is the sum of the operating cost payment amount; the capital-related cost payment; and when applicable direct medical education (DME) cost payment; indirect medical education (IME) cost payment; and a cost outlier payment. For inpatient services that are classified into a transplant diagnosis-related group, the total per discharge payment is the sum of the transplant cost-to-charge ratio (CCR) payment amount; and when applicable transplant direct medical education (DME) cost payment.

003.01 DETERMINATION OF OPERATING COST PAYMENT AMOUNT. The hospital ~~diagnosis related group~~ operating cost payment amount for discharges ~~that~~ are classified into a diagnosis-related group and is calculated by multiplying the ~~p~~Peer ~~g~~Group base payment amount by the applicable ~~national relative weight~~ 3M All-Patient Refined Diagnosis-Related Group grouper (APR DRG) National Weight.

003.01(A) CALCULATION OF THE ALL-PATIENT REFINED DIAGNOSIS-RELATED GROUP GROUPER (APR DRG) ~~APR-DIAGNOSIS RELATED GROUP~~ WEIGHTS. ~~For dates of service on or after July 1, 2014, the Department will use the All-Patient Refined Diagnosis Related Groups classifications.~~ Hospitals are expected to submit claims in compliance with All-Patient Refined Diagnosis-Related Groups grouper (APR DRG) standards. ~~The National Weights published by 3M will be applied to the all patient refined-diagnosis related groups. The National Weights are calculated using the nationwide inpatient sample released by the healthcare cost and utilization project. The Department~~

~~will annually update the all patient refined-diagnosis related group grouper and national relative weights with the most current available version~~.

003.01(B) CALCULATION OF NEBRASKA PEER GROUP BASE PAYMENT AMOUNTS. Peer ~~g~~Group base payment amounts are used to calculate payments for discharges ~~with a~~ for non-transplant diagnosis-related group. Peer ~~g~~Group base payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations. ~~effective July 1, 2016, are calculated for peer group 1, 2 and 3 hospitals based on the peer group base payment amounts effective during state fiscal year 2011, adjusted for , budget neutrality, calculated as follows: peer group 1 base payment amounts, excluding children's hospitals: multiply the state fiscal year 2011 peer group 1 base payment amount of $4,397.00 by the diagnosis related group budget neutrality factor. Children's hospital peer group 1 base payment amounts: multiply the state fiscal year 2011 children's hospital peer group 1 base payment amount of $5,278.00 by the diagnosis related group budget neutrality factor. Peer group 2 base payment amounts: multiply the state fiscal year 2011 peer group 2 base payment amount of $4,270.00 by the diagnosis related group budget neutrality factor. Peer group 3 base payment amounts: multiply the state fiscal year 2011 peer group 3 base payment amount of $4,044.00 by the diagnosis related group budget neutrality factor. State fiscal year 2007 Nebraska peer group base payment amounts are described in this chapter. Peer group base payment amounts excluding the 0.5% increase for the rate period beginning October 1, 2009 and ending June 30, 2010, will be increased by .5% for the rate period beginning July 1, 2010. The peer group base payment amount is subject to annual adjustment as specified by the Department.~~

003.02 CALCULATION OF DIAGNOSIS-RELATED GROUP COST OUTLIER PAYMENT AMOUNTS. Additional payment is made for approved discharges classified into a diagnosis-related group meeting or exceeding Nebraska Medicaid criteria for cost outliers for each diagnosis-related group classification. Cost outliers may be subject to medical review. Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education (IME) cost payment ~~amount~~, and the capital-related cost payment ~~amount~~, plus $30,000 for all neonate and nervous system ~~all-patient refined-diagnosis related groups~~ All-Patient Refined Diagnosis-Related Groups grouper (APR DRG) at severity level 3 and at severity level 4. For all other All-Patient Refined Diagnosis-Related Groups grouper (APR DRG) ~~all-patient refined-diagnosis related groups~~, the outlier threshold is the sum of the operating cost payment amount, the indirect medical education (IME) cost payment ~~amount~~, and the capital-related cost payment ~~amount,~~ plus $51,800. Cost of the discharge is calculated by multiplying the Nebraska Medicaid allowed charges by the sum of the hospital-specific Medicare operating and capital outlier cost-to-charge ratios. Additional payment for cost outliers is 80% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85% of the difference between the hospital's cost for the discharge and the outlier threshold.

003.02(A) HOSPITAL-SPECIFIC MEDICARE OUTLIER COST-TO-CHARGE RATIOS (CCR). ~~The Department will extract from the Center for Medicaid and Medicaid Services Prospective Payment System Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier cost-to-charge ratios effective October 1 of the year preceding the start of the Nebraska rate year.~~ Hospitals excluded from the Medicare prospective payment system under federal regulations will have a provider-specific cost-to-charge ratio (CCR) calculated using all-payer data from their Medicare cost report. An

out-of-state hospital's outlier cost-to-charge ratio (CCR) is the average of in-state hospitals within the same Peer Group. The cost-to-charge ratio (CCR) outlier is not subject to Nebraska Legislative appropriations.

~~003.02(B) OUTLIER COST-TO-CHARGE RATIO UPDATES. On July 1 of each year, the Department will update the outlier costs based on the Medicare outlier cost-to-charge ratios effective October 1 of the previous year.~~

003.03 CALCULATION OF DIRECT MEDICAL EDUCATION (DME) COSTS.

003.03(A) CALCULATION OF DIRECT MEDICAL EDUCATION (DME) COST PAYMENTS. Direct ~~M~~medical ~~E~~education (DME) cost payments shall be made to eligible Nebraska teaching hospitals and are based on hospital-specific direct medical education (DME) cost payment rates determined each state fiscal year. The direct medical education (DME) cost payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations. ~~effective October 1, 2009 are based on Nebraska hospital-specific direct medical education payment rates effective during state fiscal year 2007 with the following adjustments: Estimate state fiscal year 2007 direct medical education payments for in-state teaching hospitals by applying state fiscal year 2007 direct medical education payment rates to state fiscal year 2007 Nebraska Medicaid inpatient fee-for-service paid claims data. Include all patient refined-diagnosis related group discharges except psychiatric, rehabilitation and Medicaid Capitated Plans discharges. Divide the estimated state fiscal year 2007 direct medical education payments for each hospital by each hospital's number of intern and resident full time equivalents effective in the Medicare system on October 1, 2006. Multiply the state fiscal year 2007 direct medical education payment per intern and resident full time equivalent by each hospital's number of intern and resident full time equivalents effective in the Medicare inpatient system on October 1, 2008. Divide the direct medical education payments adjusted for full time equivalents effective October 1, 2008 by each hospital's number of state fiscal year 2007 claims. Multiply the direct medical education payment rates by the stable diagnosis related group budget neutrality factor. On July 1st of each year, the Department will update direct medical education payment rates by replacing each hospital's intern and resident full time equivalents effective in the Medicare inpatient system on October 1, 2008, as described in step 3 of this subsection, with each hospital's intern and resident full time equivalents effective in the Medicare inpatient system on October 1 of the previous year. The direct medical education payment amount will be increased by 0.5% effective October 1, 2009 through June 30, 2010. This rate increase will not be carried forward in subsequent years. The direct medical education payment amount, excluding the 0.5% increase effective October 1, 2009 through June 30, 2009, will be increased by .5% for the rate period beginning July 1, 2010. The direct medical education payment amount is subject to annual adjustment as specified by the Department.~~

003.03(B) CALCULATION OF INDIRECT MEDICAL EDUCATION (IME) COST PAYMENTS. ~~Hospitals qualify for indirect medical education payments when they receive a direct medical education payment from Medicaid, and qualify for indirect medical education payments from Medicare~~. Indirect medical education (IME) cost payments shall be made to eligible Nebraska teaching hospitals and are ~~Recognition of indirect medical education costs incurred by hospitals are an add-on~~ calculated by multiplying an indirect medial education (IME) factor by the operating cost payment amount. Hospitals excluded from the Medicare prospective payment system under

federal regulations will have a provider specific intern-to-bed ratio calculated using their Medicare cost report. The intern-to-bed ratio is then utilized in the following formula to calculate the annual indirect medical education (IME) factor: number of interns and residents divided by available beds; plus 1; to the power of 0.405; minus 1; multiplied by 1.35. The indirect medical education (IME) factor is not subject to Nebraska Legislative appropriations. ~~The indirect medical education factor is the Medicare inpatient prospective payment system operating indirect medial education factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating indirect medical education factor shall be determined using data extracted from the Center for Medicare and Medicaid Services Prospective Payment System Inpatient Pricer Program using the following formula: Number of interns and residents divided by available beds; plus 1; to the power of 0.405; minus 1; multiplied by 1.35.~~

~~003.03(C) CALCULATION OF MANAGED CARE ORGANIZATION MEDICAL EDUCATION PAYMENTS. Medicaid MCO Direct Medical Education payments and managed care organization indirect medical education payments for services provided by Medicaid capitated plans from discharge data provided by the managed care organization. Managed care organization direct medical education payments will be equal to the number of managed care organization discharges times the fee-for-service direct medical education payment per discharge in effect for the rate year July 1 through June 30. Managed care organization indirect medical education payments will be equal to the number of managed care organization discharges times the managed care organization indirect medical education payment per discharge. The indirect medical education payment per discharge is calculated as follows. Subtotal each teaching hospital's fee-for-service inpatient acute indirect medical education prior year payments. Subtotal each teaching hospital's fee-for-service inpatient covered prior state fiscal year charges. Divide each teaching hospital's indirect medical education payments, by covered prior state fiscal year charges. Multiply this ratio times the covered charges in managed care organization paid claims in the base year. Divide this amount by the number of managed care organization paid claims in the base year.~~

003.03(C~~D~~) CALCULATION OF CAPITAL-RELATED COST PAYMENT. Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the diagnosis-related group. Capital-related payment per diem amounts are calculated for Peer Groups 1 Metro Acute Care Hospitals, 2 Urban Acute Care and Regional Rural Referral Hospitals, 3 Rural Acute Care Hospitals and 10 Children's Hospitals. ~~effective July 1, 2009 are calculated for Peer Group 1, 2 and 3 hospitals based on the capital-related payment per diem amounts during state fiscal year 2007, adjusted for budget neutrality, as follows: Peer Group 1 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 1 Capital-related payment per diem amount of $36.00 by the Stable diagnosis related group budget neutrality factor. Peer Group 2 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 2 Capital-related payment per diem amount of $31.00 by the stable diagnosis related group budget neutrality factor. Peer Group 3 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 3 Capital-related payment per diem amount of $18.00 by the Stable diagnosis related group budget neutrality factor. Capital Related Per Diem Amounts are subject to annual adjustments as specified by the Department.~~ The Peer Group specific capital-related payment per diem amounts shall be adjusted by the available funds appropriated by the Nebraska Legislature.

003.03(D~~E~~) TRANSPLANT DIAGNOSIS-RELATED GROUP PAYMENTS. Transplant discharges, identified as discharges that are classified to a transplant diagnosis-related group, are paid a transplant diagnosis-related group cost-to-charge ratio (CCR) payment and, if applicable, a direct medical education (DME) payment. Transplant diagnosis-related group discharges do not receive separate cost outlier payments, indirect medical education (IME) cost payments ~~independent medical examination cost payments~~ or capital-related cost payments.

003.03(D~~E~~)(i) TRANSPLANT DIAGNOSIS-RELATED GROUP COST-TO-CHARGE RATIO (CCR) PAYMENTS. Transplant diagnosis-related group cost-to-charge ratio (CCR) payments are calculated by multiplying the hospital-specific transplant diagnosis-related group cost-to-charge ratio (CCR) by Nebraka Medicaid-allowed claim charges. On July 1 of each year, Nebraska Medicaid will update the transplant diagnosis-related group cost-to-charge ratios (CCR) using the following method: divide the previous year outlier cost-to-charge ratio (CCR) by the current year outlier cost-to-charge ratio (CCR) to determine the percentage of change; then multiply this by the percentage of change by the previous state fiscal year transplant cost-to-charge ratio (CCR); then multiply the product by any applicable state legislative appropriations. Out-of-state hospital transplant cost-to-charge ratio (CCR) is the average of in-state hospitals within the same Peer Group. ~~as follows: Extract from the centers for Medicare and Medicaid services prospective payment system Inpatient pricer program for each hospital the Medicare inpatient prospective payment system operating and capital outlier cost to charge effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier cost-to-charge ratio in effect for the Medicare system on October 1, 2008; sum the operating and capital outlier cost-to-charge ratio; multiply the sum of the operating and capital outlier cost-to-charge ratios by the transplant diagnosis related group budget neutrality factor. On July 1 of each year, the Department will update the Transplant diagnosis related group cost-to-charge ratios based on the percentage change in Medicare outlier cost-to-charge ratios effective October 1 of the two previous years, before budget neutrality adjustments. Effective July 1, 2011, the transplant diagnosis related group cost-to-charge ratios will be reduced by 2.5%. Effective July 1, 2012, the transplant diagnosis related group cost-to-charge ratios will be increased by 1.54%. Effective July 1, 2013, the transplant diagnosis related group cost-to-charge ratios will be increased by 2.25%. Effective July 1, 2014, the transplant diagnosis related group cost-to-charge ratios will be increased by 2.25%. Effective July 1, 2015, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 1, 2016, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 31, 2019, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 1, 2020, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%.~~

003.03(D~~E~~)(ii) TRANSPLANT DIAGNOSIS-RELATED GROUP DIRECT MEDICAL EDUCATION (DME) PAYMENTS. Transplant diagnosis-related group direct medical education (DME) cost payments are based on Nebraska hospital-specific direct medical education (DME) payment rates determined each state fiscal year. Bone marrow transplant diagnosis-related groups are excluded from transplant direct medical education (DME) rate and are reimbursed under the specific hospital direct medical education (DME) rate. ~~are calculated using the same methodology described in subsection this chapter, with the exception that in step 4, direct medical education~~

~~per discharge payment amounts are adjusted by the transplant diagnosis related group budget neutrality factor.~~ Each state fiscal year Nebraska hospital-specific transplant direct medical education (DME) payment rates shall be adjusted by a percentage. This percentage shall be determined by Nebraska Legislature appropriations. The transplant direct medical education (DME) payment rates are adjusted annually and shall be effective each July 1. ~~On July 1st of each year, the Department will update transplant direct medical education payment per discharge rates. as described in this regulation. On July 1st of each year, the Department will update transplant diagnosis related group direct medical education payment per discharge rates as described in this chapter~~.

003.03(E~~F~~) BUDGET NEUTRALITY FACTORS. Peer Group ~~B~~base ~~P~~payment ~~A~~amounts, are multiplied by budget neutrality factors in the process of setting payment rates.~~, determined as follows:~~

003.03(E~~F~~)(i) DEVELOP FISCAL SIMULATION ANALYSIS. ~~The Department~~ Nebraska Medicaid will develop a fiscal simulation analysis using Nebraska Medicaid inpatient ~~fee-for-service~~ paid claims data ~~from state fiscal year 2011~~. The fiscal simulation analysis includes discharges grouped into a diagnosis-related group and excludes all psychiatric, rehabilitation, and transplant discharges. In the fiscal simulation analysis, ~~the Department~~ Nebraska Medicaid will apply all rate year payment rates before budget neutrality adjustments to the claims data and simulate payments.

003.03(E~~F~~)(ii) DETERMINE BUDGET NEUTRALITY FACTORS. ~~The Department~~ Nebraska Medicaid will set budget neutrality factors in fiscal simulation analysis such that simulated payments are equal to the claims data reported payments, inflated by Peer Group ~~B~~base ~~P~~payment ~~A~~amount increases approved by ~~the Department~~ Nebraska Medicaid from the end of the claims data period to the rate year. ~~For rates effective July 1, 2014, the Department will inflate the state fiscal year 2011 base rates by 61.05%.~~

003.03(F~~G~~) FACILITY SPECIFIC UPPER PAYMENT LIMIT. Facilities in Peer Groups 1, 2, ~~and~~ 3, and 10 are subject to an upper payment limit for all cost reporting periods ~~ending after January 1, 2001~~. For each cost reporting period, Nebraska Medicaid payment for inpatient hospital services shall not exceed 110% of Nebraska Medicaid cost. Nebraska Medicaid cost shall be the calculated sum of Nebraska Medicaid allowable inpatient routine and ancillary service costs. Nebraska Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center. Nebraska Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio (CCR) times the applicable Nebraska Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio (CCR) 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 (DME) cost payments, indirect medical education (IME) cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Nebraska Medicaid eligible ~~patients~~ beneficiaries. Payment under Nebraska Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

003.03(FG)(i) RECONCILIATION TO FACILITY UPPER PAYMENT LIMIT. Facilities will be subject to a preliminary and a final reconciliation of Nebraska Medicaid payments to allowable Nebraska Medicaid costs. ~~A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report.~~ A reconciliation will be made within ~~6~~ six months following receipt by ~~the Department~~ Nebraska Medicaid of the facilities settled cost report. Facilities will have 60 days to make refunds to Nebraska Medicaid, when notified that an overpayment has occurred. Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Nebraska Medicaid payments more than 110% of Nebraska Medicaid costs. ~~The Department~~ Nebraska Medicaid will identify the cost reporting period for Nebraska Medicaid payments, Nebraska Medicaid costs, and the amount of overpayment that is due ~~the Department~~ to Nebraska Medicaid. ~~Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.~~

003.03(GH) TRANSFERS. When a ~~patient~~ beneficiary is transferred to or from another hospital, ~~the Department~~ Nebraska Medicaid 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~~ beneficiary remains in that hospital, up to 100 % of the full diagnosis-related group payment. The average daily rate is calculated as the full diagnosis-related group payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education (DME) cost payment, divided by the statewide average length-of-stay for the related diagnosis-related group. For hospitals receiving a transferred ~~patient~~ beneficiary, payment is the full diagnosis-related group payment and, if applicable, cost outlier payment.

003.03(HI) INPATIENT ADMISSION AFTER OUTPATIENT SERVICES. A ~~patient~~ beneficiary may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a ~~patient~~ beneficiary is admitted as an inpatient within three calendar days of the day that the hospital outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

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

003.03(JK) INTERIM PAYMENT FOR LONG-STAY ~~PATIENTS~~ BENEFICIARIES. Nebraska Medicaid's payment for hospital inpatient services is made upon the ~~patient's~~ beneficiary's discharge from the hospital. Occasionally, a ~~patient~~ beneficiary 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~~ beneficiary has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days. To request an interim payment, the hospital shall send ~~a~~ the appropriate completed Nebraska Medicaid approved health care claim form ~~Form HCFA-1450, UB-92~~, for the hospital days for which

the interim payment is being requested with an attestation by the attending physician that the ~~patient~~ beneficiary has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. ~~The hospital shall send the request for interim payment to the Department of Health and Human Services Finance and Support. The hospital will be notified in writing if the request for interim payment is denied.~~

003.03(J~~K~~)(i) FINAL PAYMENT FOR LONG-STAY ~~PATIENTS~~ BENEFICIARIES. When an interim payment is made for long-stay ~~patients~~ beneficiaries, the hospital shall submit a final billing for payment upon discharge of the ~~patient~~ beneficiary. The date of admission for the final billing must be the date the ~~patient~~ beneficiary was admitted to the hospital as an inpatient. The statement ~~"~~from~~"~~ and ~~"~~to~~"~~ dates must be the date the ~~patient~~ beneficiary was admitted to the hospital through the date the ~~patient~~ beneficiary was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

003.03(K~~L~~) PAYMENT FOR ~~NON-PHYSICIAN~~ CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) FEES. A certified registered nurse anesthetist (CRNA) provider may choose to retain their billing privileges and submit claims directly for certified registered nurse anesthetist (CRNA) charges, which would follow the anesthesia fee schedule. The critical access hospital (CAH) or rural emergency hospital may also elect one of the following two options to bill for certified registered nurse anesthetist (CRNA) professional fees on behalf of the certified registered nurse anesthetist (CRNA) provider. Certified registered nurse anesthetist (CRNA) providers in either circumstance must reassign billing privileges to the critical access hospital (CAH) or rural emergency hospital. In cases when Medicare is the primary payer, the provider must follow Medicare billing requirements. In either option below, the certified registered nurse anesthetist (CRNA) provider must not separately bill for charges that occurred in the critical access hospital (CAH) or rural emergency hospital for which they have reassigned billing privileges:

(i) A critical access hospital (CAH) may choose to bill on a professional claim form for both inpatient and outpatient certified registered nurse anesthetist (CRNA) services. A rural emergency hospital may choose to bill on a professional claim form for outpatient certified registered nurse anesthetist (CRNA) services. Reimbursement will follow the Nebraska Medicaid anesthesia fee schedule; or

(ii) The critical access hospital (CAH) may bill on an institutional claim form for both inpatient and outpatient professional certified registered nurse anesthetist (CRNA) costs using revenue code 964 for certified registered nurse anesthetist (CRNA) professional fees. Reimbursement will be based on critical access hospital (CAH) inpatient or outpatient applicable rates and are subject to cost settlement. A rural emergency hospital may bill on an institutional claim form for outpatient professional certified registered nurse anesthetist (CRNA) costs using revenue code 964 for certified registered nurse anesthetist (CRNA) professional fees. Reimbursement for rural emergency hospitals will be based on outpatient applicable rates.

~~Hospitals which meet the Medicare exception for payment of certified registered nurse anesthetist fees as a pass-through by Medicare will be paid for certified registered nurse anesthetist fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for certified registered nurse anesthetist~~

~~services. Costs will be calculated using the hospital's specific anesthesia cost-to-charge ratio. Certified registered nurse anesthetist fees must be billed using revenue code 964 - Professional Fees Anesthetist on the HCFA-1450, UB-92, claim form.~~

004. NON-PAYMENT FOR HOSPITAL ACQUIRED CONDITIONS (HAC). Nebraska 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~~ beneficiaries. This means that Nebraska Medicaid will, at a minimum, identify as ~~a~~ hospital acquired conditions (HAC), those diagnoses codes that have been identified as ~~Medicare~~ hospital acquired conditions (HAC) by the Centers for Medicare & Medicaid Services (CMS) when not present on hospital admission. Any diagnosis code(s) which are flagged as hospital acquired conditions (HAC) will be excluded from the final claim All-Patient Refined Diagnosis-Related Group grouper (APR DRG) determination.

005. PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES. Payments for psychiatric discharges are made on a prospective per diem basis. Tiered rates will be used for all acute psychiatric inpatient services. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the ~~applicable~~ per diem ~~rate~~ times the number of approved ~~patient~~ beneficiary days ~~for each tier~~. Payment is made for the day of admission, but not the day of discharge. Tiered rates are subject to annual adjustment as specified by Nebraska Legislative appropriations. ~~For payment of inpatient hospital psychiatric services, effective July 1, 2014, the tiered per diem rate will be: $715.32 for 1 and 2 days of service; $661.55 for 3 and 4 days of service; $631.18 for 5 and 6 days of service; and $601.14 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2015, the tiered per diem rate will be: $731.41 for 1 and 2 days of service; $676.43 for 3 and 4 days of service; $645.38 for 5 and 6 days of service; and $614.67 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2016, the tiered per diem rate will be: $747.87 for 1 and 2 days of service; $691.65 for 3 and 4 days of service; $659.90 for 5 and 6 days of service; and $628.50 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 31, 2019, the tiered per diem rate will be: $777.79 for 1 and 2 days of service; $719.32 for 3 and 4 days of service; $686.30 for 5 and 6 days of service; and $653.64 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2020, the tiered per diem rate will be: $809.00 for 1 and 2 days of service; $748.00 for 3 and 4 days of service; $714.00 for 5 and 6 days of service; and $680.00 for 7 and 8 days of service.~~

005.01 PAYMENT FOR PSYCHIATRIC ADULT INPATIENT SUBACUTE HOSPITAL SERVICES. Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. ~~This rate may be reviewed annually. Effective April 12, 2008, the payment for psychiatric adult subacute inpatient hospital services identified in state regulations was $488.13. Beginning July 1, 2008, the per diem rate was $505.21 and on November 24, 2009 onward the rate is $512.79.~~ The subacute inpatient hospital per diem ~~rate~~ basis is not a tiered rate. Payment will be an all-inclusive per diem basis, with the exception of physician services. Per diem payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations.

005.02 PAYMENT FOR HOSPITAL-SPONSORED PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF). Reimbursement is capped at the psychiatric residential treatment facilities' (PRTF) usual and customary daily charges billed for eligible beneficiaries. Public psychiatric residential treatment facilities (PRTF) will be cost-settled annually. Payment

rates do not include costs of providing educational, pharmacy, and physician services. Rates are subject to annual adjustment as specified by Nebraska Legislative appropriations.

006. PAYMENT FOR IN-STATE OUTPATIENT HOSPITAL AND EMERGENCY ROOM SERVICES. The starting point for the outpatient hospital and emergency services rate shall be a rate which is determined by: Peer Groups 1 Metro Acute Care Hospitals, 2 Urban Acute Care & Regional Rural Referral Hospitals, 3 Rural Acute Care Hospitals, and 10 Children's Hospitals Outpatient Rate is the Nebraska Medicaid percentage of cost to charge ratios (CCR), that is, cost divided by charges multiplied by Nebraska Medicaid percentage of allowable charges; Peer Groups 7 Critical Access Hospitals (CAH), and 8 Rural Emergency Hospitals Outpatient Rate is the ancillary and outpatient service cost center's cost to charge ratio (CCR) up to 100 percent. All outpatient clinical laboratory services must be itemized and identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure codes. Nebraska Medicaid pays for clinical laboratory services at the fee schedule determined by the Centers for Medicare & Medicaid Services (CMS).

007~~6~~. PAYMENTS FOR REHABILITATION SERVICES. Payments for rehabilitation discharges are made on a prospective per diem basis. 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 basis will be the sum of: the hospital-specific base payment per diem basis ~~rate~~; ~~the hospital-specific capital per diem rate;~~ and the hospital's direct medical education (DME) cost payment ~~per diem rate~~, if applicable. Payment for each discharge equals the per diem basis times the number of approved ~~patient~~ beneficiary days. Payment is made for the day of admission but not for the day of discharge. Per diem payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations.

007~~6~~.01 ADJUSTMENT OF HOSPITAL-SPECIFIC BASE PAYMENT AMOUNT. ~~The hospital specific per diem rates may be adjusted annually as specified by the Department.~~ The base payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations.

~~006.02 CALCULATION OF HOSPITAL-SPECIFIC CAPITAL PER DIEM RATE. Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem as described in this chapter.~~

008~~7~~. PAYMENT FOR SERVICES FURNISHED BY A CRITICAL ACCESS HOSPITAL (CAH). ~~Effective for cost reporting periods beginning July 1, 2015, and after p~~Payment for inpatient services of a critical access hospital (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 rule, ceilings on hospital operating costs, and the reasonable compensation equivalent limits for physician services to providers. Subject to the 96-hour average on inpatient stays in critical access hospitals (CAH), items and services that a critical access hospital (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.

009. PAYMENT FOR LONG-TERM ACUTE CARE HOSPITAL (LTACH) SERVICES. Payments for long-term acute care hospitals (LTACH) discharges are made on a prospective per diem basis, depending on whether the beneficiary requires ventilator or non-ventilator services, whichever is applicable, as determined by prior authorization review. A prior authorization is required for all

long-term acute care hospital (LTACH) services for either ventilator or non-ventilator services. The per diem will be the sum of long-term acute care hospital (LTACH) ventilator or non-ventilator services per diem; and direct medical education (DME) cost payment, if applicable. Payment for each discharge equals the per diem basis times the number of approved beneficiary days. Payment is made for the day of admission but not the day of discharge. Per diem payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations.

010. PAYMENT FOR OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES IN A HOSPITAL. Providers shall use Health Care Common Procedure Coding System (HCPCS) procedure codes and American Medical Association's Current Procedural Terminology when submitting claims to Nebraska Medicaid. These codes are defined on the Mental Health Substance Use Disorder Fee Schedule. Nebraska Medicaid pays for covered outpatient mental health services, except for laboratory services, at the lower of: the provider's submitted charge; or the allowable amount for that procedure code in the Nebraska Medicaid Mental Health Substance Use Disorder Fee Schedule for that date of service. Rates are subject to annual adjustment as specified by Nebraska Legislative appropriations.

011~~08~~. RATES FOR STATE-OPERATED INSTITUTIONS ~~OF~~ FOR MENTAL DISEASE (IMD). Institutions for ~~M~~mental ~~D~~disease (IMD) operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated ~~I~~institutions ~~of~~ for ~~M~~mental ~~D~~diseases (IMD) will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

012~~09~~. DISPROPORTIONATE SHARE HOSPITALS (DSH). A hospital qualifies as a disproportionate share hospital (DSH) if the hospital meets the definition of a disproportionate share hospital (DSH) and submits the required information completed, dated, and signed as follows with their Medicare cost report:

(A) The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for Nebraska Medicaid. This requirement does not apply to a hospital;
  (i) The inpatients of which are predominantly individuals under 18 years of age;
  (ii) Which does not offer non-emergency obstetric services to the general population ~~as of December 21, 1987~~; or
  (iii) For a hospital located in a rural area, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures~~.~~;

(B) Only Nebraska hospitals which have a current enrollment with Nebraska Medicaid will be considered for eligibility as a disproportionate share hospital (DSH); and

(C) When notified by Nebraska Medicaid ~~the Department~~ that the hospital qualifies as a disproportionate share hospital (DSH), each hospital must certify to Nebraska Medicaid that it has incurred costs for the delivery of uncompensated care which are equal to or exceed the amount of the disproportionate share hospital (DSH) payment.

012~~09~~.01 DISPROPORTIONATE SHARE ELIGIBILITY CALCULATION. To calculate eligibility, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a disproportionate share hospital (DSH) will be calculated using the following data.

012~~09~~.01(A) NEBRASKA MEDICAID INPATIENT UTILIZATION RATE. To determine the Nebraska 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 Nebraska Medicaid days, which includes the Nebraska Medicaid management information

system non-managed care claims file data run 150 days after each hospital's fiscal year end, managed care days for hospitals that submit a disproportionate share hospital (DSH) survey, and out-of-state days reported before the federal fiscal year for which the determination is made. ~~Only secondary payor days in the Medicaid management information system claims file data will be included.~~

012~~09~~.02~~2~~1(B) LOW INCOME UTILIZATION RATE. To determine the low-income utilization rate, data from the Nebraska accounting system will be used to calculate the low-income utilization rate for state-owned institutions for mental disease (IMD). For all other hospitals, the hospital's certified report of total revenue, Nebraska Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

012~~09~~.02 DISPROPORTIONATE SHARE HOSPITAL (DSH) UPPER PAYMENT LIMIT AND UNCOMPENSATED CARE CALCULATION. The ~~D~~disproportionate ~~S~~share ~~H~~hospital (DSH) upper payment limit and the uncompensated care calculation is the sum of the Nebraska Medicaid shortfall plus the cost of uninsured care.

(A) ~~The Department~~ Nebraska Medicaid will calculate the Nebraska Medicaid shortfall as follows:

(i) ~~The Department~~ Nebraska Medicaid will determine the costs of Nebraska Medicaid fee-for-service and managed care inpatient services by:

(1) Calculating a hospital's routine cost per day for each cost center from the Centers for Medicare ~~and~~ & Medicaid Services (CMS) ~~2552~~ cost report by dividing the total costs by the total days; and

(2) Multiplying the cost per day times the number of Nebraska Medicaid allowable days provided during the same fiscal year as the filed cost report and paid up to 150 days after the end of the fiscal year~~.~~;

(ii) ~~The Department~~ Nebraska Medicaid will determine costs of Nebraska Medicaid fee-for-service and managed care outpatient services by:

(1) Calculating a hospital's ancillary cost-to-charge ratio (CCR) from the Centers for Medicare ~~and~~ & Medicaid Services (CMS) ~~2552~~ cost report; and

(2) Multiplying the total Nebraska Medicaid allowable charges times the ancillary cost-to-charge ratio (CCR)~~.~~;

(iii) The total Nebraska Medicaid cost is the sum of the inpatient and outpatient costs for each hospital; and

(iv) The Nebraska Medicaid shortfall is determined by subtracting the total allowable Nebraska Medicaid payments from the total Nebraska Medicaid cost.

(B) ~~The Department~~ Nebraska Medicaid will calculate the cost of uninsured care by using each hospital's charges for services provided to uninsured ~~patients~~ beneficiaries as filed and certified to ~~the Department~~ Nebraska Medicaid for the same fiscal year as the Centers for Medicare ~~and~~ & Medicaid Services (CMS) cost report used in determining costs. ~~The Department~~ Nebraska Medicaid will convert each hospital's charges to cost for uninsured patients by multiplying the charges by the overall cost-to-charge ratio (CCR) determined using each hospital's Centers for Medicare ~~and~~ & Medicaid Services (CMS) ~~2552~~ report for the same fiscal year used in determining cost~~; and~~.

(C) The Nebraska Medicaid upper payment limit and the uncompensated care amount shall be the sum of the Nebraska Medicaid shortfall plus the cost of uninsured care.

012~~09~~.03 DISPROPORTIONATE SHARE PAYMENTS. Disproportionate share payments will be made each federal fiscal year following receipt of all required data by ~~the Department~~

Nebraska Medicaid. The total of all disproportionate share payments must not exceed the limits on disproportionate share hospital (DSH) funding ~~as~~ established for this State by the Centers for Medicare ~~and~~ & Medicaid Services (CMS) in accordance with federal law ~~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.

012~~09~~.03(A) METHODS. ~~For federal fiscal year 2007 and succeeding years, the Department~~ Nebraska Medicaid will make a disproportionate share hospital (DSH) payment to hospitals that qualify for a payment under one of the following ~~p~~Pool distribution methods.

012~~09~~.03(A)(i) BASIC DISPROPORTIONATE SHARE PAYMENT POOL 1. Pool 1 consists of eligible hospitals in ~~p~~Peer ~~g~~Groups 2 Urban Acute Care & Regional Rural Referral Hospitals, 3 Rural Acute Care Hospitals, and 7 Critical Access Hospitals (CAH) ~~2, 3, and 6~~ that are not eligible under ~~p~~Pool 6.

012~~09~~.03(A)(i)(1) POOL 1 FUNDING. Total funding to Pool 1 will be $1,000,000. In federal fiscal year 2008 and following years, this amount will be increased by the percentage change in the consumer price index for all urban consumers, all items, United States ~~(U.S.)~~ city average. ~~The Department~~ Nebraska Medicaid will calculate the payment for Pool 1 as follows: ~~F~~first, each hospital's Nebraska Medicaid days, which include days from the Nebraska Medicaid management information system claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made, will be divided by the sum of the Nebraska Medicaid inpatient days of all hospitals which qualify for a payment in ~~p~~Pool 1. Second, the ratio resulting from such division will be multiplied times the total funding for ~~p~~Pool 1 to determine each hospital's payment. If payment to a hospital exceeds the federally determined disproportionate share hospital (DSH) payment limit, ~~as established under section 1923(f) of the Social Security Act,~~ the payment will be reduced~~.~~ and ~~If payment is reduced to a hospital within Pool 1,~~ the additional funds will be redistributed pro rata to eligible hospitals within ~~p~~Pool 1.

012~~09~~.03(A)(ii)~~(i)(2)~~ BASIC DISPROPORTIONATE SHARE PAYMENT POOL 2. Pool 2 consists of eligible hospitals in Peer Groups 1 Metro Acute Care Hospitals, 2 Urban Acute Care & Regional Rural Referral Hospitals, and 3 Rural Acute Care Hospitals ~~Peer Groups 1, 2, and 3~~ that are also eligible under Pool 6.

012~~09~~.03(A)(ii)(1)~~(i)(2)(a)~~ POOL 2 FUNDING. ~~Total funding to pool 2 will be $3,154,000 for federal fiscal year 2007, and $2,654,000 for federal fiscal year 2008.~~ For federal fiscal year 2009 and following years, the total funding will be the amount for federal fiscal year 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers, all items, United States ~~(U.S.)~~ city average. ~~The Department~~ Nebraska Medicaid will calculate the payment for ~~p~~Pool 2 as follows. First, each hospital's Nebraska Medicaid days, which include days from the Nebraska Medicaid management information system claims file data run 150 days after each hospital's fiscal year end, managed care

days, and out-of-state days reported before the federal fiscal year for which the determination is made, will be divided by the sum of the Nebraska Medicaid inpatient days of all hospitals which qualify for a payment in ~~p~~Pool 2. Second, the ratio resulting from such division will be multiplied times the total funding for Pool 2 to determine each hospital's payment. If payment to a hospital exceeds the federally determined disproportionate share hospital (DSH) payment limit, ~~as established under 1923 (f) of the Social Security Act,~~ the payment will be reduced~~.~~ and ~~If payment is reduced to a hospital within pool 2,~~ the additional funds will be redistributed pro rata to eligible hospitals within ~~p~~Pool 2.

012~~09~~.03(A)(iii)~~(i)(3)~~ DISPROPORTIONATE SHARE PAYMENT FOR HOSPITALS THAT PRIMARILY SERVE CHILDREN POOL 3. Pool 3 consists of the eligible hospital in Peer Group 10 Children's Hospitals ~~that both primarily serves children under the age of 20 and under and~~ that has the greatest number of Nebraska Medicaid days.

012~~09~~.03(A)(iii)(1)~~(i)(3)(a)~~ POOL 3 FUNDING. ~~Total funding for pool 3 will be $3,138,000 for federal fiscal year 2007, and $3,638,000 for federal fiscal year 2008.~~ For federal fiscal year 2009 and following years, the total funding will be the amount for federal fiscal year 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers, all items, United States ~~(U.S.)~~ city average. A hospital eligible for payment under this ~~p~~Pool will not be eligible for payment under any other ~~p~~Pool. If payment to the hospital exceeds the federally determined disproportionate share hospital (DSH) payment limit, ~~as established under 1923(f) of the Social Security Act,~~ the payment will be reduced.

012~~09~~.03(A)(iv)~~(i)(4)~~ DISPROPORTIONATE SHARE PAYMENT FOR STATE OWNED INSTITUTIONS FOR MENTAL DISEASE (IMD) HOSPITALS AND FOR ELIGIBLE HOSPITALS IN PEER GROUP ~~4~~ 5 POOL 4. Pool 4 consists of state-owned institutions for mental disease (IMD) and other eligible hospitals in Peer Group 5 Mental Health or Psychiatric Inpatient Hospitals ~~Peer Group 4~~.

012~~09~~.03(A)(iv)(1)~~(i)(4)(a)~~ POOL 4 FUNDING. Total funding for Pool 4 will be $1,811,337 annually. ~~The Department will calculate payments as follows.~~ Each eligible hospitals must certify in writing to the Nebraska Medical Assistance Program its charges for uncompensated care for the hospital's fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospitals cost-to-charge ratio (CCR). Payment to each hospital will be equal to the cost of its uncompensated care. If the total of all disproportionate share payment amounts for ~~p~~Pool 4 exceeds the federally determined disproportionate share hospital (DSH) limit for Nebraska, the disproportionate share hospital (DSH) payments will be reduced pro rata.

012~~09~~.03(A)(v)~~(i)(5)~~ NON-PROFIT ACUTE CARE TEACHING HOSPITAL AFFILIATED WITH A STATE-OWNED UNIVERSITY MEDICAL COLLEGE POOL 5. Pool 5 consists of the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this ~~p~~Pool may be eligible for payment under Pool 6.

012~~09~~.03(A)(v)(1)~~(i)(5)(a)~~ POOL 5 FUNDING. Total funding to Pool 5 will be $15,000,000. For federal fiscal year ~~FFY~~ 2008 and following years the funding will be increased annually by the percentage change in the consumer price index for all urban consumers, all items, United States ~~(U.S.)~~ city average. ~~The Department~~ Nebraska Medicaid will calculate the disproportionate share hospital (DSH) payment to Pool 4 ~~5~~ as an amount equal to the cost of its uncompensated care. If the payment to the hospital exceeds the federally determined disproportionate share payment limit, ~~as established under 1923(f) of the Social Security Act,~~ the payment will be reduced.

012~~09~~.03(A)(vi)~~(i)(6)~~ UNCOMPENSATED CARE POOL 6. Pool 6 consists of hospitals that provide services to low-income persons covered by a county administered general assistance program; or hospitals that provide services to low-income persons ~~covered~~ served by the ~~state administered public~~ behavioral health regions ~~system~~.

012~~09~~.03(A)(vi)(1)~~(i)(6)(a)~~ POOL 6 FUNDING. Total funding to Pool 6 will be the remaining federal and state balance of the disproportionate share hospital (DSH) ~~balance~~ total funding~~, federal and state, disproportional share hospital funding~~ minus the funding for ~~p~~Pools 1, 2, 3, 4, and 5~~,~~. ~~The Department~~ Nebraska Medicaid will calculate payments as follows: disproportionate share hospital (DSH) payments to a hospital under all other ~~p~~Pools will be subtracted from the hospital's disproportionate share hospital (DSH) upper payment limit before allocating payments under ~~p~~Pool 6. The costs for uncompensated care resulting from participation county administered general assistance program will be reported by the county; and costs for the state administered public behavioral health system will be reported by each hospital and funding will be transferred to Nebraska Medicaid. Reported costs will be subject to audit by ~~the Department~~ Nebraska Medicaid. ~~A ratio for each hospital will be determined based on the uncompensated cost for each hospital to the total of uncompensated cost for all hospitals in pool 6. The ratio for each hospital will be multiplied times the available funding to the Pool to yield each hospital' annual payment amount.~~ The total computable payment will be commensurate with the charges for uncompensated care resulting from participation in county administered general assistance program; or the ~~state administered public~~ behavioral health regions ~~system~~. ~~The annual payment amount will be dispersed in twelve monthly payments.~~ If payment to the hospital exceeds the federally determined disproportionate share payment limit, ~~as established under 1923(g) of the Social Security Act,~~ the payment will be reduced to the payment limit. If payments to hospitals under this ~~p~~Pool exceed the total allotment to Nebraska, the payments will be reduced pro rata.

012~~09~~.03(B) LIMITATIONS ON DISPROPORTIONATE SHARE PAYMENTS. No payments made under this section will exceed any federally determined applicable limitations upon such payments ~~established by Section 1923(g)(1)(A) of the Social Security Act~~. Disproportionate ~~S~~share hospital (DSH) payments to all qualified hospitals for a year will not exceed the federally determined State disproportionate share hospital (DSH) payments limit~~, as established under 1923 (f) of the Social Security Act~~.

~~009.04 REDISTRIBUTION OF DISPROPORTIONATE SHARE HOSPITAL OVERPAYMENTS. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of~~

~~disproportionate share hospital payments, the Department will implement procedures to comply with federally determined the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009. Beginning in disproportionate share hospital state plan rate year 2011, if the results of audits conducted in accordance with the disproportionate share hospital final rule indicate that a hospital has exceeded the hospital specific disproportionate share hospital limit the amount of the payment that exceeds the of disproportionate share hospital payment that is more than uncompensated care costs will be recouped. Any funds recouped shall first be recouped from pool 1 through 5 payments and then from pool 6 payments and shall be redistributed to other eligible hospitals within the State, provided each hospital remains below their hospital specific disproportionate share hospital limit. Funds recouped from Pools 1 through 6 shall first be redistributed to each eligible hospital in the pool in which the hospital payment was recouped. Any recouped funds that are not able to be distributed within the pool will accumulate and be redistributed to all eligible hospitals.~~

~~009.04(A) CALCULATION. The Department will calculate the redistribution as follows: First, for each pool in which funds were recouped beginning with Pool 1 and proceeding in pool numerical order, each hospital's difference between their disproportionate share hospital payment and disproportionate share hospital limit will be calculated. The difference will be divided by the sum of the difference between the disproportionate share hospital payment and disproportionate share hospital limit for all hospitals in the pool. Second, the ratio resulting from such division will be multiplied times the total funding recouped for the pool to determine each hospital's redistribution payment. If the sum of the original disproportionate share hospital payment and redistribution payment exceeds the disproportionate share hospital payment limit, the payment will be reduced. If payment is reduced to a hospital within a pool, the additional funds will be redistributed pro rata to eligible hospitals within the pool. If all hospitals within the Pool have reached their disproportionate share hospital limit, the remaining funds will be carried forward to be redistributed to all eligible hospitals. For pool 6, each hospital's difference between their disproportionate share hospital payment and disproportionate share hospital limit will include funds redistributed from pools 1 through 5 above.~~

~~009.04(B) FINAL REDISTRIBUTION. The final redistribution will be calculated as follows: First, for any funds that were not redistributed for each pool in which funds were recouped, each hospitals, except for pool 4 institutions of mental disease difference between their disproportionate share hospitals payment and disproportionate share hospitals limit will be calculated. The difference will be divided by the sum of the difference between the disproportionate share hospitals payment and disproportionate share hospitals limit for all non-institutions of mental disease hospitals. Second, the ratio resulting from such division will be multiplied times the total recouped funding not already distributed to determine each hospital's redistribution payment. If the sum of the original disproportionate share hospital payment and redistribution payment exceeds the disproportionate share hospitals payment limit, the payment will be reduced. If payment is reduced to a hospital, the additional funds will be redistributed pro rata to eligible non-institutions of mental disease hospitals within the pool. If all non-institutions of mental disease hospitals have reached their disproportionate share hospital limit, the federal portion of remaining funds will be returned to the Centers for Medicare and Medicaid Services.~~

0~~1~~3~~10~~. OUT-OF-STATE HOSPITAL RATES. ~~The Department pays o~~Out-of-state hospitals are paid for hospital inpatient services using the same methods described in this chapter for in-state hospitals, except that out-of-state hospitals do not receive direct medical education (DME) cost

payments, indirect medical education (IME) cost payments or graduate medical education payments. Payments for services are determined by assigning out-of-state hospitals to the appropriate Peer Group.

(A) Peer Group 1: Metro Acute Care Hospitals, Peer Group 2: Urban Acute Care & Regional Rural Referral Hospitals, Peer Group 3: Rural Acute Care Hospitals, and Peer Group 10: Children's Hospitals;
  (i) Operating costs payment amounts are calculated based on the appropriate Peer Group base payment amount;
  (ii) Capital-related cost payment are made based on the appropriate Peer Group capital per diem rate;
  (iii) Outpatient rates will be the average of the in-state Peer Group;
  (iv) Cost-to-charge ratio (CCR) outlier will be the average in-state by Peer Group; and
  (v) Cost-to-charge ratio (CCR) transplant will be the average in-state by Peer Group;

(B) Peer Group 5: Mental Health or Psychiatric Hospitals: tiered rates per diem will be used for all psychiatric services and are the same of the in-state hospitals;

(C) Peer Group 6: Physical Rehabilitation Hospitals: payments are made on a prospective per diem for rehabilitation hospitals are based on average of the in-state rehabilitation hospitals per diem rates;

(D) Peer Group 7: Critical Access Hospitals (CAH);
  (i) Acute per diem payment will be the average of in-state hospitals;
  (ii) Bassinet or nursery per diem will be the average of in-state hospitals; and
  (iii) Outpatient rates will be the average of in-state critical access hospitals (CAH);

(E) Peer Group 8: Rural Emergency Hospitals: outpatient rates will be the average of in-state rural emergency hospitals; and

(F) Peer Group 9: Long-Term Acute Care Hospitals (LTACH): payments are made on a prospective per diem for long term acute care hospitals are based on average of the in-state rehabilitation hospitals per diem rates.

~~at the peer group rate for a like peer group of Nebraska hospitals. The peer groups are: metro acute care hospitals, hospitals located in a metropolitan statistical area as designated by Medicare; rural acute care hospitals, all other acute care hospitals; psychiatric hospitals and distinct part units in acute care hospitals, hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in this chapter; and rehabilitation hospitals and distinct part units in acute care hospitals, hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in this chapter. Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. Effective September 1, 2003, capital costs will be calculated as 96.85% of the peer group weighted median cost per day. The cost-to-charge ratio is the peer group average. Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. The Department may allow payments to out-of-state hospitals for direct or indirect medical education costs at a negotiated per discharge rate~~.

~~010.01 EXCEPTION. The Administrator of the Medicaid Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in this chapter only when the Medical Director of the Department has determined that:~~

~~(A) The client requires specialized services that are not available in Nebraska; and~~

~~(B) No other source of the specialized services can be found to provide the services at the rate established in this chapter.~~

~~011.~~ ~~OUT-OF-PLAN SERVICES.~~ ~~When enrollees in the Nebraska Health Connection are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are authorized, but are not required, to pay providers of hospital inpatient services who care for individuals enrolled in the Nebraska Health Connection at rates the Department would otherwise reimburse providers under this chapter.~~

014~~11~~. 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 Nebraska Medicaid for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. ~~The hospital's rate is calculated according to this chapter. This is an exception to policies related to the elimination of combined billing in this chapter.~~

015. PAYMENT FOR NON-ACUTE ADMIN DAYS. A per diem for hospital care is paid when a Nebraska Medicaid beneficiary, who is an inpatient, no longer requires acute inpatient care and requires nursing facility level of care (LOC) upon discharge but is unable to be transferred to a nursing facility due to a lack of available nursing facility beds, or in cases when the transfer requires a guardian, a guardian has not been appointed. Prior authorization for non-acute admin days is required by Nebraska Medicaid.

016. PAYMENT FOR SWING BED SERVICES. A per diem that includes post-hospital 24-hour skilled nursing care services that must be provided by or under the direct supervision of professional or technical personnel and requires skilled knowledge, judgment, observation, and assessment. This per diem payment includes all items and services aside from ancillary services and therapies. Prior authorization for admission to a swing bed is required by Nebraska Medicaid.

017~~12~~. 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 this chapter ~~these regulations~~.

018~~13~~. 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 (DME) amount, if applicable, indirect medical education (IME) amount, if applicable, cost-to-charge ratio (CCR), outpatient percentage, capital amount, and any other applicable rates or add-ons. The weights shall equal each hospital's base year Nebraska Medicaid discharges as a proportion of total Nebraska Medicaid discharges for the merged hospitals and shall be applied to the current fiscal year rates which were calculated for each hospital.

019~~14~~. RATE-SETTING FOR A NEW OPERATIONAL FACILITY. ~~The Department shall establish a~~ The prospective per discharge rate for a new operational facility ~~for Peer Groups 1-5~~. ~~The rate~~ will be the average P~~p~~eer G~~g~~roup rate for the respective P~~p~~eer G~~g~~roup for the new facility. ~~For critical access hospitals, the rate will be determined individually for each hospital based on reasonable cost. The peer groups are: Metro acute care hospitals, hospitals located in a metropolitan statistical area as designated by Medicare; Other urban acute care hospitals, hospitals that have been redesignated to an metropolitan statistical area by Medicare for federal fiscal year 1995 or 1996 or hospitals designated by Medicare as a regional rural referral center; rural acute care hospitals, all other acute care hospitals with 30 or more base year Medicaid~~

~~discharges; Psychiatric Hospitals and distinct part units in acute care hospitals, hospitals that are licensed as psychiatric hospitals by the Department and distinct parts as defined in these regulations; Rehabilitation hospitals and distinct part units in acute care hospitals, hospitals that are licensed as rehabilitation hospitals by the Department and distinct parts as defined in these regulations; and critical access hospital, hospitals that are certified as critical access hospitals by Medicare.~~

020~~15~~. DEPRECIATION. ~~The Department~~ Nebraska Medicaid 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.

021~~16~~. RECAPTURE OF DEPRECIATION FROM HOSPITAL. A hospital which is sold for a profit and has received Nebraska Medicaid payments for depreciation, shall refund to ~~the Department~~ Nebraska Medicaid the lower of: the amount of depreciation allowed and paid by ~~the Department~~ Nebraska Medicaid; or the product of the ratio of Nebraska Medicaid allowed inpatient days to total inpatient days; and the amount of gain on the sale as determined by the Medicare intermediary. The year or years for which depreciation is to be recaptured is determined by the Medicare ~~I~~intermediary according to Medicare principles of reimbursement.

022~~17~~. ADJUSTMENT TO RATE. Changes to Nebraska Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by ~~the Department~~ Nebraska Medicaid. 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~~ Nebraska Medicaid ~~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~~.

023~~18~~. LOWER LEVELS OF CARE (LOC). When ~~the Department~~ Nebraska Medicaid determines that a ~~client~~ beneficiary no longer requires inpatient services but requires ~~skilled~~ nursing facility care and there are no ~~skilled~~ nursing beds available when the determination is made or when the transfer requires a guardian, ~~the Department~~ Nebraska Medicaid 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~~ beneficiary day paid by ~~the Department~~ Nebraska Medicaid to ~~skilled~~ nursing facilities during the previous calendar year. A prior authorization is required. ~~When a Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process, the Department may pay for the pre-admission screening process days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. The hospital shall request prior authorization from the Medicaid Division before the pre-admission screening process days are provided. The Medicaid Division will send the authorization to the hospital. The hospital shall bill for class of care 81 and enter the prior authorization document number from Form MC-9 on Form HCFA-1450 (UB-92). The claim for the pre-admission screening process days must be separate from the claim for the inpatient days paid at the acute rate. The pre-admission screening process days will be disallowed as acute care days and Medicaid will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the pre-admission screening process day. Pre-admission screening process days will not be considered in computing the hospital's prospective rate.~~

02419. ACCESS TO RECORDS. Hospitals shall make all records relating to the care of Nebraska Medicaid patients beneficiaries and all other cost information available to the Department Nebraska Medicaid, its designated representatives or agents, or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours. Hospitals shall allow authorized representatives of the Department Nebraska Medicaid 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 Nebraska Medicaid. 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.

02520. AUDITS. The Department Nebraska Medicaid 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 Nebraska Medicaid, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department Nebraska Medicaid. Audits will be performed as determined appropriate by the Department Nebraska Medicaid.

02621. 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 this title 471 NAC 2. A hospital may also request an adjustment to its rate.

02722. REQUEST FOR RATE ADJUSTMENTS. Requests for rate adjustments are subject to the rules contained in this section.

02722.01 REQUESTS. Hospitals may submit a request to the Department Nebraska Medicaid for an adjustment to their rates for the following:

(A) An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate iIf the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate;

(B) Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate fFor extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. Extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. Extraordinary circumstances are limited to:

(i) Changes in routine and ancillary costs, which are limited to:

(1) Intern and resident related medical education costs; and

(2) Establishment of a subspecialty care unit.; and

(ii) Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.; or

(C) Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate iIf they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:

(i) One-time occurrence;

(ii) Less than twelve-month duration;

(iii) Could not have been reasonably predicted;

(iv) Not of an insurable nature;
(v) Not covered by federal or state disaster relief; and
(vi) Not a result of malpractice or negligence.

~~022.02 CALCULABLE. 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.~~

0~~27~~22.03~~2~~ ~~RATE ADJUSTMENT~~ REQUIREMENTS. ~~In making a~~ A request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following~~,~~: changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, 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, or extraordinary circumstances beyond the hospital's control; and every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. ~~The Department~~ Nebraska Medicaid may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. ~~The Department~~ Nebraska Medicaid may require an on-site operational review of the hospital be conducted by ~~the Department~~ Nebraska Medicaid or its designee.~~; the rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.~~ 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.

0~~27~~22.04~~3~~ ~~RATE ADJUSTMENT REQUEST~~ SUBMISSION. Requests for rate adjustments must be submitted in writing to Nebraska Medicaid ~~the Division~~. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, ~~the Department~~ Nebraska Medicaid 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~~ Nebraska Medicaid's receipt of the request. Regardless of ~~the Department's~~ Nebraska Medicaid'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~~ Nebraska Medicaid's decision. Following review of the matter, ~~the administrator~~ Nebraska Medicaid 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~~ Nebraska Medicaid. If rate relief is granted because 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 Nebraska Medicaid cost, calculated in conformity with this Nebraska Medicaid cost calculation methodology. Nebraska Medicaid's decision regarding rate adjustment requests is final and non-appealable.

~~022.05 APPLICABILITY. If rate relief is granted because of a rate adjustment request, the relief applies only to the rate year for which the request is submitted, except for corrections of~~

~~errors in rate determination. If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.~~

~~022.06 NO EXCEEDING ACTUAL MEDICAID COST. Under no circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology.~~

028. HOSPITAL QUALITY ASSURANCE AND ACCESS ASSESSMENT. A hospital shall pay its quarterly assessment within 30 days after receipt of its quarterly directed payments.

028.01 DETERMINATION OF NET PATIENT REVENUE. The hospital cost reports, which are extracted from the Healthcare Cost Report Information System on Nebraska Medicaid's extraction date, will be considered final for purposes of determining the hospital's net patient revenue for their prospective quality assurance assessment amount.

028.02 NON-PAYMENT OF QUALITY ASSURANCE AND ACCESS ASSESSMENT. Failure of a hospital to remit the assessments may result in penalties, interest, or legal action. Providers that fail to remit the assessments in 30 days are subject to sanctions listed in Nebraska regulations.