

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

“This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Nebraska Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document.”

Pursuant to
Neb. Rev. Stat. § 84-901.03

To: All Providers Participating in the Nebraska Medicaid Program
From: Drew Gonshorowski, Director *DG*
Date: April 7, 2026
Re: Non-Acute Admin Day Per Diem Rate

This provider bulletin is being issued to **rescind and replace Provider Bulletin 25-08** provide updated guidance related to Nebraska Medicaid beneficiaries who no longer meet acute inpatient hospital level of care and meet nursing facility level of care but cannot be discharged to a nursing facility for certain reasons as listed below in the Nebraska Revised Statute § 68-1009. The purpose of this provider bulletin is to notify Nebraska Medicaid-participating inpatient (IP) hospital providers of this updated guidance on non-acute admin day coverage.

Background

[Nebraska Revised Statute § 68-1009](#) requires that:

The state shall provide Medicaid reimbursement to a hospital at one hundred percent of the statewide average nursing facility per diem rate for an individual if the individual: (a) is enrolled in the medical assistance program; (b) has been admitted as an inpatient to such hospital; (c) no longer requires acute inpatient care and discharge planning as described in 42 C.F.R. 482.43; (d) requires nursing facility level of care upon discharge; and (e) is unable to be transferred to a nursing facility due to a lack of available nursing facility beds available to the individual or, in cases where the transfer requires a guardian, has been approved for appointment of a public guardian and the State Court Administrator is unable to appoint a public guardian.

Authorization

A prior authorization is required for Nebraska Medicaid coverage of non-acute admin days. When requesting prior authorization for the non-acute admin days, please follow the standard prior authorization request process for the applicable Nebraska Medicaid payer. Please request **procedure code S9976** (lodging, per diem, not elsewhere classified). The prior authorization review process will confirm that the patient receiving care meets the criteria listed in Neb. Rev. Stat. § 68-1009. If the patient has a payer source other than Nebraska Medicaid, a denial from the primary payer is not required at the time the prior authorization request is submitted for the non-acute admin days. The start date for coverage of the non-acute admin days must be the day the patient meets the criteria listed in Neb. Rev. Stat. § 68-1009.

For fee-for-service beneficiaries, the authorization request must be sent by secure email to dhhs.mltcutilizationmanagement@nebraska.gov. The authorization form MS-77 can be found on the DHHS Forms and Publications website at <https://dhhs.ne.gov/Pages/Forms.aspx>.

For managed care beneficiaries, please contact the applicable Nebraska Medicaid payer's provider services department if you have further questions regarding the authorization process.

- **Molina:** 844-782-2678 TTY 711 or Fax to 833-832-1015
- **Nebraska Total Care:** Please fax the Inpatient Medicaid Prior Authorization Form to 1-844-845-5086.
- **UnitedHealthcare:** 866-331-2243 TTY 711

Reimbursement & Billing

Please visit <https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx> for annual rate updates. The fee schedule is listed under *Hospital Non-Acute Admin Level of Care*.

Nebraska Medicaid recognizes there may be situational cases during hospital non-acute admin days where a patient may need ancillary services, such as maintenance physical/occupational/speech therapy, laboratory services, radiology or medications. However, Neb. Rev. Stat § 68-1009 does not provide Nebraska Medicaid authority to reimburse for these services. For purposes of this program, these services are inclusive of the per diem rate.

Additionally, the following billing guidance must be followed:

- Providers must submit a UB-04 (institutional) claim billing with the procedure code S9976 (lodging, per diem, not elsewhere classified) with revenue code 160 (other general room/board) and number of units based on the number of days the Medicaid beneficiary was in the hospital and met the conditions of payment as defined in Neb. Rev. Stat. § 68-1009.
- The hospital must continue to submit a separate claim for acute inpatient level of care and a separate claim for the non-acute admin days. Providers will not receive reimbursement if the acute inpatient claim and the non-acute admin days claim are combined into a single claim.
- Both claims must utilize the appropriate admission date (which can be either the acute inpatient admission date or the admission date for non-acute admin days) when Nebraska Medicaid is the primary payer.
- The hospital acute inpatient level of care claim must reflect discharge status code 30 (still a patient) or discharge status code 70 (discharged/transferred to another type of health care institution not defined elsewhere in this code list).
- The hospital must bill with the appropriate number of units (relative to authorized days and for the date span on their non-acute admin day claim). It is critical that hospitals follow the MCO's non-acute admin day prior authorization process as part of their claim submission for those days.

When Nebraska Medicaid is secondary to another primary insurance (i.e. Medicare, private/commercial insurance, etc.), hospitals are expected to exhaust all primary payer sources in alignment with 471 NAC 3, Section 005.01, which states in part that Nebraska Medicaid is the payer of last resort and that Nebraska Medicaid payment is made only after all third-party resources have been exhausted or met their legal/contractual obligations to pay.

When a primary payer exists, Nebraska Medicaid expects hospitals to submit the primary payer's explanation of benefits (EOB) from the *inpatient acute care stay* as part of its claim submission to the applicable Nebraska Medicaid payer for hospital non-acute admin days. Specifically, the EOB will need to indicate the dates of service that the primary insurance payer covers for the inpatient acute care claim. Nebraska Medicaid will require a primary payer EOB with the hospital's claim submission for

non-acute admin days. The non-acute admin day claim start date should be the day following the last covered day for inpatient acute care stay by the primary insurance payer.

Timely Filing

Please refer to [471 Nebraska Administrative Code \(NAC\) Chapter 3](#) for rules regarding the timely submission of claims.

Provider Resources

For further information, please see the [Hospital Non-Acute Admin Day Questions and Answers](#) document posted on the [Medicaid Providers](#) webpage.

Provider Bulletins, such as this one, are posted on the DHHS website at <http://dhhs.ne.gov/pages/Medicaid-Provider-Bulletins.aspx>. Please subscribe to the page to help you stay up to date about new Provider Bulletins.

If you have questions regarding this bulletin, please contact Danny Vanourney, Rates and Reimbursement Administrator, at (402) 471-3368, or via email at: danny.vanourney@nebraska.gov. Health plans should also copy their contract manager.