CHAPTER 10-000 HOSPITAL SERVICES

10-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), a hospital that provides hospital inpatient and/or outpatient/emergency room services must -

1. Be maintained primarily for the care and treatment of patients with disorders other than mental disease;
2. Be licensed as a hospital by the Nebraska Department Health and Human Services Regulation and Licensure or the officially designated authority for state standard-setting in the state where the hospital is located;
3. Have licensed and certified hospital beds; and
4. Meet the requirements for participation in Medicare and Medicaid.

10-001.01 Provider Agreement: To participate in NMAP, a hospital shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," (see 471-000-91) and submit the completed form to the Nebraska Department of Health and Human Services Finance and Support for approval and enrollment as a provider.

To continue participation in NMAP, the Medicaid Division staff must receive a copy of Form CMS-1539, "Medicare/Medicaid Certification and Transmittal" (see 471-000-66) from the Nebraska Department of Health and Human Services Regulation and Licensure, indicating that the hospital is certified.

10-001.01A Out-of-State Hospital Provider Agreement: Each out-of-state hospital shall submit the following:

1. A completed and signed Form MC-20, "Medical Assistance Hospital Provider Agreement;" and
2. The hospital's certification/accreditation status from the state survey agency in the state where the hospital is located.

The Nebraska Medical Assistance Program shall not process an out-of-state hospital's claim until all information required under this section has been received.

See 471 NAC 10-010.03H, Out-of-State Hospital Rates, and 10-010.06F, Payment to an Out-of-State Hospital for Outpatient Hospital and Emergency Room Services.

10-001.02 Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Health Connection, which is Nebraska's Medicaid Managed Care Program. See 471-000-122 for a listing of the NHC plans.

10-001.02A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and claim submission instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 10-005.20, certain transplants such as liver, kidney, heart, and bone marrow, continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;
2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and
3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). The client must be able to obtain family planning services upon request and from any appropriate provider who is enrolled in NMAP. Family planning services are reimbursed by the HMO, regardless of whether the service is provided by a PCP enrolled with the HMO or a family planning provider outside the HMO.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP (see exceptions above). The provider shall provide services only under arrangement with the HMO.

10-001.02B Primary Care Case Management (PCCM) Plans: All NMAP policies under this chapter apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 10-005.01, the provider shall obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 10-005.20, transplants are subject to prior authorization by NMAP; and
2. Abortions: As currently defined, abortions require prior authorization by NMAP.

10-001.02B1 Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP shall authorize the services to be provided by the approved provider as needed with the following exceptions:

1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers shall contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.

2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 must bill that service on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837), using CPT procedure codes. These services require referral/ authorization from the client's PCP. The provider must contact the PCP before providing these services. If a client requires hospitalization for dental treatment or for medical and surgical services billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837), the provider must contact the PCP for referral/authorization.
3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 2-006.05, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

10-001.02C Mental Health and Substance Abuse Services: Mental health and substance abuse services (MH/SA) are provided by a prepaid health plan (PHP) for all NHC clients. The PHP includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization from the PHP. All other MH/SA services must be prior authorized by the PHP as directed by the plan.

10-001.03 Definitions: The following definitions apply in this chapter.

Client: An individual who is eligible for the Nebraska Medical Assistance Program.

Diagnostic Service: An examination or procedure to which the patient is subjected or which is performed on materials obtained from the patient to provide information for the diagnosis or treatment of a disease or to assess a medical condition. This may include radiological and pathological services.

Hospital-Affiliated Ambulatory Surgical Center (HAASC): An ambulatory surgical center operated by a hospital (i.e., under common ownership, licensure, or control of a hospital). An HAASC may be covered under Medicare (and therefore under the Nebraska Medical Assistance Program) as an ASC or an HAASC. A facility operated by a hospital as a Medicare-participating ASC is paid according to 471 NAC 26-005. Other HAASC's are paid according to 471 NAC 10-010.06.

Hospital Emergency Services: Services that are necessary to prevent the death of the client or serious impairment of the client's health and, because of the threat to the life or health of the client, necessitate the use of the most accessible hospital equipped to provide the necessary services.

Hospital Inpatient Services: Medically necessary services that are furnished in a hospital for the care and treatment of an inpatient under the direction of a licensed practitioner under the scope of his/her licensure.

Hospital Outpatient Observation Services: Observation services are those services furnished by a hospital on the hospital premises, including use of a bed and periodic monitoring by a hospital's nursing staff or other staff which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Most observation services do not exceed 1 day. Some patients may require a second day of outpatient observation services. A maximum of 48 hours of observation may be reimbursed. When a client receives hospital observation services and is thereafter admitted as an inpatient of the same hospital, the hospital observation services are included in the hospital's payment for the inpatient services.

Hospital Outpatient Services: Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients under the direction of a physician or dentist in an institution that meets the standards for participation in 471 NAC 10-001.

When a client receives hospital outpatient/emergency room services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the hospital outpatient/emergency room services are included in the hospital's payment for the inpatient services.

Hospital outpatient services furnished in the outpatient/emergency room to a patient classified as "dead on arrival" are covered through pronouncement of death, providing the hospital considers these patients as outpatients for recordkeeping purposes and follows its usual outpatient billing practices for services to all patients. This coverage does not apply if the patient was pronounced dead before arrival at the hospital.

Inpatient: NMAP classifies a person as an inpatient when the following occurs:

1. A person has been admitted to a hospital for bed occupancy to receive hospital inpatient services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that s/he will remain at least overnight and occupy a bed even though it later develops that s/he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight;
2. The patient has been formally admitted as an inpatient and death occurs before 24 hours elapse. These services are counted as one inpatient day.

All services are subject to review for appropriateness and medical necessity of the admission and/or level of care provided as required by 471 NAC 10-010.11.

Inpatient Days: A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Medicaid reporting purposes, even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. The day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day. (Charges for ancillary services on the day of discharge or death or the day on which a patient begins a leave of absence are covered.) If inpatient admission and discharge or death occur on the same day, the day is considered a day of admission and counted as one inpatient day.

When a registered inpatient is occupying any other ancillary area, such as surgery or radiology, at the census-taking hour before occupying an inpatient bed, the patient's occupancy must not be recorded as an inpatient day in the ancillary area; however, the patient must be included in the inpatient census of the routine care area.

The Department utilizes the current Medicare methodology in accounting for the inpatient accommodations on the Medicare cost report.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, that a prudent lay person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman and her unborn child) afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person.

Neonatal Intensive Care: Intensive care services provided to an infant in an intensive care unit specially equipped to care for such infants.

Non-Patient: An individual receiving services who is neither an inpatient nor an outpatient. When a sample or specimen is obtained by personnel not employed by the hospital and is sent to the hospital for tests, the tests are non-patient services because the patient is not registered as an inpatient or an outpatient of the hospital. If the sample is obtained by hospital personnel, the tests are outpatient services.

Nursery Care: Services for a newborn child from time of birth to time of discharge of the mother from the facility. Hospitals reimbursed by per diem shall bill nursery care unless the newborn -

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

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

If a patient receives 24 hours or more of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed and whether s/he remained in the hospital past midnight or the census-taking hour.

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

Patient: An individual who is receiving medically necessary services directed by a licensed practitioner, under the scope of his/her licensure, toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

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

Therapeutic Services: Services provided on an inpatient or outpatient basis which are incident to the services of the physicians in the treatment of patients.

10-001.04 Summary of Forms and Standard Electronic Transactions: The following forms and transactions are used in this chapter:

1. Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). Note: Instructions for completing Form CMS-1450 have been published in the Nebraska Uniform Billing Data Element Specifications manual published by the Nebraska Uniform Billing Committee. Providers may purchase copies from the Nebraska Association of Hospitals and Health Systems. For instructions to the electronic transaction, see claim submission table at 470-000-49;
2. Form CMS-1539, "Medicare/Medicaid Certification and Transmittal" (see 471-000-66);
3. Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91);
4. Form MMS-100, "Sterilization Consent Form" (see 471-000-109);
5. Form MMS-101, "Informed Consent Form" (see 471-000-110);
6. Form MS-6, "Ambulatory Room and Board Agreement" (see 471-000-73); and
7. MC-9, "Prior Authorization Document" (see 471-000-202) or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50);
8. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transactions Instructions at 471-000-50)
9. The standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277) (see Standard Electronic Transactions Instructions at 471-000-50).

Instructions and examples appear in the appendix at the end of this title.

10-001.05 Definition of Medical Necessity: NMAP defines medical necessity as follows:

Medical Necessity: Health care services and supplies which are medically appropriate and -

1. Necessary to meet the basic health needs of the client;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;

4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

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

10-002 Covered Inpatient Services: Payment for services described in this section is included in the hospital's payment for inpatient services (see 471 NAC 10-010.03).

10-002.01 Class of Care: The Nebraska Medical Assistance Program covers the following classes of care:

1. Outpatient;
2. Acute;
3. Psychiatric (only for licensed psychiatric beds);
4. Rehabilitation (only if licensed rehabilitation beds); and
5. Nursery (Bassinet).

Beginning with dates of service October 16, 2003, level of care value codes will no longer be used to determine class of care. The provider shall use the appropriate bill type on the claim (see Claim Submission Table at 471-000-49).

10-002.02 Bed and Board: The Nebraska Medical Assistance Program pays the same amount for inpatient services whether the client has a private room, a semiprivate room (two-three- or four-bed accommodations), or ward accommodations.

10-002.03 Passes or Leaves of Absence: The day on which a client begins a pass or leave of absence may be treated as a day of discharge. Therapeutic passes will be evaluated for medical necessity and are subject to medical review or the Department's utilization review (UR) activities. The hospital is not paid for therapeutic passes or leave days. See 471 NAC 10-010.11. Note: For psychiatric services, see 471 NAC 20-000. For mental health and substance abuse services for children and adolescents, see 471 NAC 32-000.

10-002.04 Nursing Services: Nursing and other related services and use of hospital facilities for the care and treatment of inpatients are included in the hospital's payment for inpatient services.

Note: The services of a private-duty nurse or other private-duty attendant are not covered as a hospital service (see 471 NAC 13-000, Nursing Services). Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient.

10-002.05 Services of Interns and Residents-In-Training: NMAP covers the reasonable cost of the services of interns or residents-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council of Dental Education of the American Dental Association.

Note: See 471 NAC 10-010.03B6a, Calculation of Direct Medical Education Cost Payments and 471 NAC 10-010.03B6b, Calculation of Indirect Medical Education Cost Payments.

10-002.05A Approved Programs for Podiatric Interns and Residents-In-Training: The services of interns and residents-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association are covered under NMAP on the same basis as the services of other interns and residents-in-training in approved teaching programs.

10-002.06 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.03. These services must be prior authorized by the Medical Services Division of the Department of Social Services.

10-003 Ancillary Services: Payment for the ancillary services described in this section is included in the payment for inpatient services. Outpatient services must be claimed using the appropriate national standard code sets, such as HCPCs and CPT.

10-003.01 Blood Administration: Since the Medicare blood deductible applies only to blood costs, and does not apply to blood processing costs, it is necessary that hospitals distinguish between those two costs under the following rules -

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

2. Blood Processing: A hospital's blood processing costs consists of amounts spent to process and administer blood after it has been procured, including -
   a. The cost of such activities as storing, typing, cross-matching, and transfusing blood;
   b. The cost of spoiled or defective blood; and
   c. The portion of the outside blood source's blood fee which remains after credit is given for replacement.

   Note: Autologous blood donation processing costs ARE not covered for reimbursement by the NMAP.

For Medicare/Medicaid clients, NMAP covers the first three pints of blood. NMAP covers any blood administration not covered by Medicare or other third-party insurance if it is medically necessary.

10-003.02 Drugs

10-003.02A Inpatient Drugs: NMAP covers drugs for use in the hospital which are ordinarily provided by the hospital for the care and treatment of inpatients. Payment for inpatient drugs is included in the hospital's payment for inpatient services.

10-003.02B Hospital Outpatient or Emergency Room Drugs: NMAP covers drugs utilized in the actual treatment as part of the outpatient or emergency room service. The hospital shall bill drugs used in the outpatient or emergency room service by National Drug Code (NDC) on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). Providers must also report the quantity and unit of measure of the NDC. Include the correct NDC information on all claims, including Medicare and other third party claims.

10-003.02C Take-Home Drugs: NMAP covers take-home drugs under 471 NAC 16-000 only when the hospital employs a registered pharmacist and has a licensed pharmacy. Claims must be submitted via the NE-POP system or on the universal drug claim.

10-003.03 Medical Supplies and Equipment: The Department uses the following definitions:

Medical Supplies: Expendable or specified reusable supplies required for care of a medical condition and used in the client's home must be prescribed by a physician or other licensed practitioner within the scope of his/her licensure. This includes dressings, colostomy supplies, catheters, and other similar items.

Durable Medical Equipment: Equipment which -

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

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

Prosthetic: A device which replaces a missing part of the body. NMAP does not cover external powered prosthetic devices.

10-003.03A Inpatient Supplies and Equipment: NMAP covers supplies and equipment provided to inpatients for use during the inpatient stay. These are included in the hospital's payment for inpatient services.

Certain items used during the client's inpatient stay are included in the hospital's payment for inpatient services even though they leave the hospital with the client. This includes items used in the actual treatment of the patient which are permanently or temporarily inserted in or attached to the patient's body.

10-003.03B Hospital Outpatient and Emergency Room Supplies and Equipment: NMAP covers medically necessary supplies and equipment used for outpatient and emergency room services. This includes items used in the actual treatment of the patient as well as items necessary to facilitate the patient's discharge. These services are claimed in a summary bill format on Form CMS-1450 or the standard electronic Health Care Claim: Institutional Transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49).

10-003.03C Take-Home Supplies and Equipment: NMAP may cover, for the patient's convenience upon discharge, up to a 10-day supply of take-home medical supplies.

10-003.03C1 Inpatient Services: Up to a 10-day supply of take-home supplies following an inpatient stay is an allowable cost and is included in the hospital's payment for inpatient services. The supplies must be billed on the appropriate claim or electronic format (see Claim Submission Table at 471-000-49).

10-003.03C2 Outpatient Services: Up to a 10-day supply of take-home supplies may be covered as an outpatient service. Supplies must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate revenue code.

10-003.03C3 Durable Medical Equipment: Take-home durable medical equipment, including orthotics and prosthetics, must be obtained from and billed by the appropriate provider. Exception: See 471 NAC 10-005.22 ff. regarding rental of apnea monitors and 471 NAC 10-005.22 ff. regarding rental of home phototherapy units.

10-003.04 Personal Care Items: NMAP covers personal care items, such as lotion, toothpaste, admit kits, etc., when they are necessary for the care of a client during inpatient or outpatient services.

10-003.05 Radiology and Pathology: NMAP covers medically necessary radiological and pathological services provided to inpatients and outpatients. NMAP covers only those services which are directly related to the patient's diagnosis. On claims for radiology and pathology, the provider must indicate the diagnosis which reflects the condition for which the service is performed, and if necessary, include a notation on the claim which documents the need.

Prior Authorization of Radiology Procedures: Effective September 1, 2009, all non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans will require prior authorization. See 471 NAC 18-004.30A. These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room.

10-003.05A Outpatient Diagnostic Services Provided by Arrangement: NMAP covers medically necessary diagnostic services provided to an outpatient by arrangement (i.e., another hospital or independent clinical laboratory).

10-003.05A1 Diagnostic Services Provided by an Independent Clinical Laboratory: An independent clinical laboratory is one which is independent both of an attending or consulting physician's office and of a hospital. A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered to be a consulting physician.

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

A clinical laboratory must meet the following criteria:

1. When state or applicable local law provides for licensing of independent clinical laboratories, the laboratory must be licensed under the law; and
2. The laboratory must also meet the health and safety requirements prescribed by the Secretary of Health and Human Services.

Note: A radiological laboratory is not considered an "independent laboratory" under NMAP.

10-003.05A2 Billing Cost for Diagnostic Laboratory Services Obtained by Arrangement: When a hospital obtains laboratory tests for nonpatients under arrangements with an independent laboratory or other hospital laboratory, either the originating hospital (or hospital lab) may claim all tests or the originating hospital and reference lab may claim the tests each performs. (See 471 NAC 10-010.06 for payment of hospital outpatient services and clinical laboratory services.)

Handling charges are not allowed when a specimen is referred by one laboratory to another.

10-003.05B Specimen Collection Fees: Separate charges made by laboratories for drawing or collecting specimens are allowable whether or not the specimens are referred to another hospital or laboratory for testing. This fee will be paid to the provider who extracted the specimen from the patient. Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. A specimen collection fee is allowed for activities such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from a patient who resides in a nursing facility or who is homebound. The technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization. A specimen collection fee is not allowed for a visiting technician when a patient in a facility is not confined to the facility or when the facility has personnel on duty qualified to perform the specimen collection.

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

A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal, such as a throat culture, a routine capillary puncture, or a pap smear.

10-003.05C Professional and Technical Components for Hospital Diagnostic and Therapeutic Services: Hospital diagnostic and therapeutic services are procedures performed to determine the nature and severity of an illness or injury, or procedures used to treat disease or disorders. Hospital diagnostic and therapeutic services include both hospital inpatient and outpatient services.

Hospital diagnostic and therapeutic services are comprised of two distinct elements: the professional component and the technical component. Examples of hospital services which have professional and technical components are -

1. Pathology/Laboratory:
   a. Anatomical;
   b. Clinical;
2. Radiology:
   a. Diagnostic radiology;
   b. Diagnostic ultrasound;
   c. Therapeutic radiology;
   d. Nuclear medicine;
3. Anesthesia;
4. Psychiatric services; and
5. Miscellaneous diagnostic and therapeutic services:
   a. Dialysis;
   b. Gastroenterology;
   c. Otorhinolaryngologic;
   d. Cardiovascular;
   e. Pulmonary;
   f. Allergy and clinical immunology;
   g. Neurology and neuromuscular;
   h. Chemotherapy;
   i. Dermatology;
   j. Physical medicine;
   k. Special services and reports; and
   l. Surgery.

NMAP may designate other services as having professional and technical components when the services are identified.

10-003.05D Professional Component: The professional component of hospital diagnostic and therapeutic services includes those physician's services directly related to the medical care of the individual patient (i.e., interpretation of laboratory tests, x-rays, EKG's, EEG's, etc.). A physician includes not only a specialist but also a physician who normally performs or supervises these services for all inpatients and outpatients of a hospital, even though the physician does not otherwise specialize in this field (i.e., laboratory, radiology, cardiopulmonary).

The professional component must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) or the appropriate claim for the provider, such as the American Dental Association (ADA) dental claim form except for facilities paid under an all-inclusive rate.

10-003.05D1 Coverage Conditions: To be covered as a professional component, the physician's services must -

1. Be personally provided to an individual patient by a physician;
2. Contribute directly to the diagnosis or treatment of an individual patient;
3. Ordinarily require performance by a physician;
4. Be medically necessary; and
5. For anesthesiology, laboratory, or radiology services, meet the requirements of 471 NAC 10-003.05F4, 10-003.05F5, or 10-003.05F6.

10-003.05E Technical Component: The technical component of hospital diagnostic and therapeutic services is comprised of two distinct elements -

1. Physicians' professional services not directly related to the medical care of the individual patient (i.e., teaching, supervision, administration, and other services that benefit the hospital's patients as a group); and
2. Hospital services (i.e., equipment, supplies, technicians, etc.).

The hospital shall claim the technical component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment for the technical component of inpatient services is included in the hospital's payment for inpatient services whether provided directly or under arrangement with an outside provider. The hospital is responsible for payment of all services provided to an inpatient under arrangement by an outside provider (except ambulance services, see 10-003.05F1d) to the outside provider (for inpatient services) if the service is provided under arrangement.

The technical component of outpatient and nonpatient services must be claimed by the provider actually providing the service. The Department's payment for the technical component includes payment for all non-physician services required to provide the procedure. Stat fees, specimen handling, call back, room charges, etc., are not reimbursed separately.

10-003.05E1 Non-Physician Services and Items: The elimination of combined billing requires the separation of physician services (professional component) from non-physician services (technical component) for billing purposes.

All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics, prosthetics, etc.), provided to hospital inpatients or outpatients must be billed by the hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) and must be provided directly by the hospital or under arrangements. If the services or items are provided under arrangements, the hospital is responsible for payment to the non-physician provider or supplier. The Nebraska Medical Assistance Program prohibits the "unbundling" of costs by hospitals for non-physician services or supplies provided to hospital patients, including ancillary services provided by another hospital.

All other non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics and prosthetics, etc.) provided to non-patients must be billed by the provider/supplier of the service or item on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Exception: Rental of apnea monitors.

Payment for the technical component for a medically necessary service required and/or ordered by a physician must be claimed by the hospital as a hospital service on the appropriate claim form or electric format (see Claim Submission Table at 471-000-49).

10-003.05E1a Inpatient Services: All non-physician services, drugs, and items provided to hospital inpatients must be billed by the hospital as ancillary services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). The hospital's payment for inpatient services includes payment for all ancillary services, including -

1. Outpatient and emergency room services provided by the hospital before admission; and
2. Outpatient or inpatient services provided by another hospital or free-standing medical facility (i.e., an ambulatory surgical center (ASC)) to an inpatient of the original admitting facility.

The hospital is responsible for payment of the service to the non-physician provider or supplier.

10-003.05E1b Outpatient Services: All non-physician services, drugs, and items provided to hospital outpatients must be billed by the hospital as hospital outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). All non-physician services, drugs, and items provided by a non-physician provider or supplier to a hospital outpatient must be billed by the hospital as a hospital outpatient service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment for these services is made according to 471 NAC 10-010.06 ff. The hospital is responsible for payment to the non-physician provider or supplier.

All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics and prosthetics, etc.) provided in the emergency room or outpatient facility must be billed by the hospital as outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

All non-physician services, drugs, medical supplies, and items provided to non-patients must be billed by the non-physician provider or supplier on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Exception: Apnea monitors (see 471 NAC 10-005.21 ff.).

The rental or sale of durable medical equipment must be billed by the supplier on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Exception: Apnea monitors (see 471 NAC 10-005.21 ff.).

10-003.05E1c Inpatient Services and Fittings: Durable medical equipment, orthotics and prosthetics, fittings, etc., provided to a hospital inpatient when the item is provided while the client is an inpatient must be billed by the hospital as an ancillary service. Payment for durable medical equipment, orthotics, and prosthetics, etc., for hospital inpatients is included in the hospital's payment for inpatient services. The hospital is responsible for payment to the supplier.

Exception: In the event a customized wheelchair for primary use in other than the hospital setting is needed for training purposes while the client is a hospital inpatient, the non-hospital supplier/provider may deliver the wheelchair to the client during the inpatient stay and bill NMAP. This exception does not apply to other items provided for use in the hospital setting.

Fittings for durable medical equipment, orthotics and prosthetics, etc., provided to a hospital inpatient when the item is provided after the client is dismissed from the hospital must be billed to the Department by the non-hospital supplier/provider.

10-003.05E1d Ambulance Services: A hospital-based ambulance service is an ambulance service owned and operated by a hospital. Providers of ambulance services shall meet the licensure and certification requirements of the Nebraska Department of Health.

10-003.05E1d(1) Covered Services: NMAP covers medically necessary and reasonable ambulance services required to transport a client to obtain or after receiving Medicaid-coverable medical care.

To be covered by NMAP, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP shall not make payment for ambulance service. Claims for ambulance services must include adequate documentation for determination of medical necessary.

10-003.05E1d(2) Billing for Hospital-Based Ambulance Services: Hospital-based ambulance services provided to an inpatient or an outpatient must be claimed on the appropriate claim format or electronic format (see Claim Submission Table at 471-000-49) as a hospital outpatient service by the hospital-based ambulance provider. Hospital-based ambulance services are reimbursed as a hospital outpatient service (see 471 NAC 10-010.06). Hospital-based ambulance costs are not included in the calculations for hospital inpatient rates.

Charges for ambulance services provided by an independent ambulance provider, regardless of whether the patient is an inpatient or outpatient, must be submitted on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) by the ambulance provider.

10-003.05E1d(3) Ground Ambulance Services

10-003.05E1d(3)(a) Basic Life Support (BLS) Ambulance: A BLS ambulance provides transportation plus the equipment and staff needed for basic services such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, cardio-pulmonary resuscitation (CPR), defibrillation, etc.

10-003.05E1d(3)(b) Advanced Life Support (ALS) Services: An ALS ambulance provides transportation and has complex specialized life-sustaining equipment and, ordinarily, equipment for radio-telephone contact with a physician or hospital. An ALS ambulance is appropriately equipped and staffed by personnel trained and authorized to provide specialized services such as administering IV's (intravenous therapy), establishing and maintaining a patient's airway, defibrillating the heart, relieving pneumothorax conditions, and performing other advanced life support procedures or services such as cardiac (EKG) monitoring.

10-003.05.E1d(3)(c) Base Rates: Ground ambulance base rates include all services, equipment and other costs, including: vehicle operating expenses, services of two attendants and other personnel, overhead charges (linens, etc.), reusable and disposable items and supplies, oxygen, pharmaceuticals, unloaded and in-town mileage, and usual waiting/standby time.

10-003.05E1d(3)(d) Mileage: "Loaded" mileage (i.e., miles traveled while the client is present in the ambulance vehicle) is covered for out-of-town ambulance transports. Out-of-town transports are defined as trips in which the final destination of the client is outside the limits of the town in which the trip originated. "Unloaded" mileage is included in the payment for the base rate.

10-003.05F1d(3)(e) Third Attendant: A third attendant is covered only if the circumstances of the transport requires three attendants. Payment for a third attendant cannot be made when the third attendant is -

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

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

10-003.05F1d(3)(f) Waiting or Standby Time: Waiting or standby time is separately reimbursed only when "unusual circumstances" exist. The "unusual circumstances" including why the ambulance waited and where the wait took place (e.g., the client's home, hospital, nursing facility, etc.) must be documented on or with the claim when billing NMAP.

When waiting time is covered, the first one-half hour is not reimbursed. Payment for waiting time under normal circumstances is included in the payment for the base rate.

10-003.05E1d(4) Air Ambulance: NMAP covers medically necessary air ambulance services only when transportation by ground ambulance is contraindicated and -

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

When billing NMAP, the provider shall bill air ambulance services as a single charge which includes base rate and mileage. The number of "loaded" miles must be included on the claim.

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

10-003.05E1d(5) Limitations and Requirements for Certain Ambulance Services

10-003.05E1d(5)(a) Emergency and Non-Emergency Transports: Emergency transports are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in -

1. Placing the client's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Any ambulance transport that does not meet the definition of an emergency transport must be billed as a non-emergency transport This includes all scheduled runs (regardless of origin and destination) and transports to nursing facilities or to the client's residence.

10-003.05E1d(5)(b) Transports to the Facility Which Meets the Needs of the Client: Ambulance services are covered to enable the client to obtain medical care in a facility or from a physician/practitioner that most appropriately meets the needs of the client, including -

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

10-003.05E1d(5)(c) Transports To A Physician/Practitioner's Office, Clinic or Therapy Center: Emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered. Non-emergency ambulance transports to a physician or practitioner's office, clinic or therapy center are covered when -

1. The client is bed confined before, during, and after transport; and
2. The services cannot or cannot reasonably be expected to be provided at the client's residence (including a nursing facility or ICF/MR).

10-003.05E1d(5)(d) Round Trip Transports for Hospital Inpatients: Ambulance services provided to a client receiving hospital inpatient services, where the client is transported to another facility for services (e.g., diagnostic testing) and the client is returned to the originating hospital for continuation of inpatient care, are not included in the payment to the hospital for inpatient services and must be billed by the hospital-based ambulance provider.

10-003.05E1d(5)(e) Combined ALS/BLS Transports: When a client is transferred from a BLS vehicle to an ALS ambulance, the ALS service may be billed, however only one ambulance provider may submit the claim for the service.

When the placement of ALS personnel and equipment on board a BLS vehicle qualifies the BLS vehicle as an ALS ambulance, the ALS service may be billed.

10-003.05E1d(5)(f) Transport of More Than One Client: When more than one client is transported during a single trip, a base rate is covered for each client transported. The number of "loaded" miles and mileage charges must be prorated among the number of clients being billed. A notation that the mileage is prorated and why must be on or with the claim when billing NMAP.

10-003.05E1d(5)(g) Transport of Medical Teams: Transport of a medical team (or other medical professionals) to meet a client is not separately reimbursed. If the transport of the medical team results in an ambulance transport of the client, the services are included in the base rate of the client's transport.

10-003.05E1d(5)(h) Transport of Deceased Clients: Ambulance services are covered if the client is pronounced dead while enroute to or upon arrival at the hospital. Ambulance services are not covered if a client is pronounced dead before the client is transported.

10-003.05F Billing for the Professional and Technical Components of Hospital Inpatient and Outpatient Diagnostic and Therapeutic Services: The professional component of hospital diagnostic and therapeutic services must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (or ADA dental claim form or the standard electronic Health Care Claim: Dental (ASC X12N 837 for dentists) except for facilities paid under an all-inclusive rate.

10-003.05F1 Technical Component: The technical component of hospital diagnostic and therapeutic services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). The technical component of hospital inpatient services must be billed as an ancillary charge. Payment is made according to 471 NAC 10-010.03 ff. The technical component of hospital outpatient services must be billed on the appropriate form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

10-003.05F2 Professional Component: The Department requires a separate Medicaid provider number for each hospital professional component specialty. A separate provider agreement (Form MC-19) is required for each separate provider number. The professional component must be billed on Form CMS-1500, or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate provider number for the professional component of the appropriate specialty.

A hospital may act as the billing agent for the physician's professional component.

Only one specialty (one provider number) may be billed on each Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F3 Pre-Admission Testing: Payment for pre-admission testing as an ancillary service is included in the hospital's payment for inpatient services. Diagnostic services rendered up to three days before the day of admission are included in the inpatient hospital payment.

NMAP does not cover pre-admission testing performed in a physician's office or as an outpatient which is performed solely to meet hospital pre-admission requirements.

10-003.05F4 Anesthesiology

10-003.05F4a Professional Component: The Department covers, as a physician's service, the professional component of anesthesiology services provided by a physician to an individual patient if the conditions in 471 NAC 10-003.05D1 are met. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Claims for these services must indicate actual time in one-minute increments.

Note: Rural hospitals that have been exempted by their Medicare fiscal intermediary for certified registered nurse anesthetist (CRNA) billing shall follow the Medicare billing requirements.

10-003.05F4b Medical Direction of Four or Fewer Concurrent Procedures: The professional component for the physician's personal medical direction of concurrent anesthesiology services provided by qualified anesthetists, such as certified registered nurse anesthetists (CRNA's), is covered as a physician's service when the services meet the requirements listed in 471 NAC 10-003.05D1 and the following additional requirements:

1. For each patient, the physician -
    a. Performs and documents a pre-anesthetic examination and evaluation;
    b. Prescribes the anesthesia plan;
    c. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

d. Ensures that any procedures in the anesthesia plan that s/he does not perform are performed by a qualified individual;
e. Monitors the course of anesthesia administration at frequent intervals;
f. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
g. Provides indicated post-anesthesia care; and

2. The physician directs no more than four anesthesia procedures concurrently, and does not provide any other services while directing the concurrent procedures (see 471 NAC 10-003.05F4b(1)); and
3. The physician certifies on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) that s/he directed services to no more than four patients concurrently.

Claims for these services must indicate actual time in one-minute increments.

Claims for the physician's medical direction of four or fewer concurrent services provided by qualified anesthetists not employed by the physician must indicate actual time in one-minute increments.

The physician's medical direction of four or fewer concurrent anesthesia procedures is considered a professional component and must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

Claims for anesthesia services for hospital inpatients or outpatients provided by anesthetists who are not employees of a physician must be billed as a technical component as follows:

1. Inpatient services must be billed as an ancillary service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.03 ff.
2. Outpatient services must be billed using the appropriate revenue code for hospital outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

10-003.04F2b(1) Other Services Provided While Directing Concurrent Procedures: A physician who is directing concurrent anesthesia services for four or fewer surgical patients must not ordinarily be involved in providing additional services to other patients. The following situations are examples of services that do not constitute a separate service for determining medical direction in item 2 of 471 NAC 10-003.05F4b:

1. Addressing an emergency of short duration in the immediate area;
2. Administering an epidural or caudal anesthetic to ease labor pain;
3. Periodic, rather than continuous, monitoring of an obstetrical patient;
4. Receiving patients entering the operating suite for the next surgery;
5. Checking or discharging patients in the recovery room; or
6. Handling scheduling matters.

If the physician leaves the immediate area of the operating suite for longer than short durations, devotes extensive time to an emergency case, or is otherwise not available to respond to the immediate needs of surgical patients, the physician's services to the surgical patient are supervisory in nature and are considered a technical component; therefore, these services must be billed as the technical component by the hospital. The technical component of hospital inpatient services must be billed as an ancillary service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.03 ff. The technical component of hospital outpatient services must be billed using the appropriate revenue code for hospital outpatient services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

10-003.05F4c Supervision of More Than Four Concurrent Procedures: If the physician is involved in providing direction for more than four concurrent procedures or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are covered as the technical component of the hospital services. The technical component must be billed as described in 471 NAC 10-003.05F1. The physician shall ensure that a qualified individual performs any procedure in which the physician does not personally participate. The professional component of personal services up to and including induction is covered as a physician's service and must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F4d Standby Anesthesia Services: A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs and ready to furnish anesthesia services to a specific patient who is known to be in potential need of services. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F4e Claims for Payment: The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The technical component must be billed as described in 471 NAC 10-003.05F1.

10-003.05F4f Anesthesiology: The hospital may engage the services of a nurse anesthetist (either on a salary or fee-for-service basis) under arrangements which provide for billing to be made by the hospital. Reimbursement for the service when provided to an inpatient or outpatient is included in the payment rate under NMAP (see 471 NAC 10-010.03 and 10-010.06).

10-003.05F5 Laboratory/Pathology

10-003.05F5a Professional Component: The Department covers as a physician's service the professional component of laboratory services provided by a physician to an individual patient only if the services meet the requirements listed in 471 NAC 10-003.05D1 and are -

1. Anatomical pathology services;
2. Consultative pathology services, which must -
   a. Be requested by the patient's attending physician;
   b. Relate to a test result that lies outside the clinically significant normal or expected range in view of the patient's condition;
   c. Result in a written narrative report included in the patient's medical record; and
   d. Require the exercise of medical judgment by the consulting physician; or
3. Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F5b Clinical Lab Services: Clinical laboratory services provided to hospital inpatients, outpatients, and non-patients are routinely performed by non-physicians (i.e., medical technologists or laboratory technicians) manually or using automated laboratory equipment. These clinical laboratory services do not require performance by a physician and are considered a technical component; there is no professional component for these services. The technical component must be billed as described in 471 NAC 10-003.05F1. Payment is made to the hospital as follows:

1. Inpatient Services: Payment is included in the hospital's payment for inpatient services. The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate;
2. Outpatient Services: Payment is made at the fee schedule determined by CMS (see 471-000-520);
   Note: Outpatient clinical laboratory services must be itemized on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure codes (see 471 NAC 10-010.06).
3. Non-Patient Services: Payment is made at the fee schedule determined by CMS. (See 471-000-520)

10-003.05F5b1 Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.03B1b, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

There is no separate payment made to the pathologist for routine clinical lab services. To be paid, the pathologist must negotiate with the hospital to arrange a salary/compensation agreement.

10-003.05F5c Leased Departments: Leased department status has no bearing on billing or payment for clinical lab services. The hospital shall claim all clinical lab services, whether performed in a leased or non-leased department. Payment for the total service (professional and technical component) is made to the hospital. The Department does not make separate payment for the professional component for clinical lab services.

10-003.05F5d Anatomical Pathology Services: Anatomical pathology services are services which ordinarily require a physician's interpretation. If these services are provided to hospital inpatients or outpatients, the professional and technical components must be separately identified for billing and payment.

10-003.05F5e Billing and Payment for Hospital Inpatient Anatomical Pathology Services: Payment for the technical component of anatomical pathology is included in the hospital's payment for inpatient services which is claimed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as an ancillary service. The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate.

The pathologist shall claim the professional component of anatomical pathology on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code and a "26" modifier. This service is paid according to the Nebraska Medicaid Practitioner Fee Schedule.

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

10-003.05F5f Billing and Payment for Hospital Outpatient Anatomical Pathology Services: The hospital shall bill the technical component of outpatient anatomical pathology services in a summary bill format using the appropriate revenue code on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The pathologist shall claim the professional component on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code and a "26" modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

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

10-003.05F5g Billing and Payment for Non-Patient Anatomical Pathology Services: For specimens from non-patients referred to the hospital, the hospital shall bill the total service (both professional and technical components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate revenue code. Payment is made according to 471 NAC 10-010.06 ff.

10-003.05F5h Leased Departments: If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist must claim the total service (professional and technical components) on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

Leased department status has no bearing on billing for or payment for hospital inpatient or outpatient anatomical pathology services.

10-003.05F6 Radiology: All radiology services have a technical component and a professional component (physician interpretation). The professional and technical component of hospital services must be separately identified for billing and payment.

10-003.05F6a Professional Component: The professional component of radiology services provided by a physician to an individual patient is covered as a physician's service when the services meet the requirements listed in 471 NAC 10-003.05D1 and the services are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-003.05F6b Technical Component: The technical component of hospital radiology services, such as administrative or supervisory services or services needed to produce the x-ray films or other items that are interpreted by the radiologist, must be billed as described in 471 NAC 10-003.05F1.

10-003.05F6c Billing and Payment for Hospital Inpatient Radiology Services: Payment for the technical component of inpatient radiology services is included in the hospital's payment for inpatient services. These costs may be included on the hospital's cost report to be considered in calculating the hospital's payment rate.

Physicians must claim the professional component of inpatient radiology services on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code with a "26" modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

10-003.05F6d Billing and Payment for Hospital Outpatient Radiology Services: The hospital must claim the technical component of outpatient radiology services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The physician must claim the professional component on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate HCPCS procedure code with a "26" modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

10-003.05F6e Billing and Payment for Non-Patient Radiology Services: A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. If a radiology procedure is performed for a non-patient, the hospital must claim the total component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

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

10-003.05G Computerized Tomography (CT) Scans: NMAP covers diagnostic examinations of the head (head scans) and of certain other parts of the body (body scans) performed by computerized tomography (CT) scanners when -

1. Medical and scientific literature and opinion support the use of a scan for the condition;
2. The scan is reasonable and necessary for the individual patient; and
3. The scan is performed on a model of CT equipment that meets Medicare's criteria for coverage.

10-003.05H Radiology and Pathology for Annual Physical Exams for Clients Residing in Nursing Facilities and ICF/MR's: The Nebraska Department of Health requires that all long term care facility residents have an annual physical examination. The physician, based on his/her authority to prescribe continued treatment, determines the extent of the examination for NMAP clients based on medical necessity. For the annual physical exam, a CBC and urinalysis will not be considered "routine" and will be reimbursed based on the physician's orders. The results of the examination must be recorded in the client's medical record.

NMAP does not cover routine laboratory and radiology services which are not directly related to the patient's diagnosis and treatment. In order to be reimbursed for a CBC and urinalysis, the hospital must note on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) that these services were performed for an annual physical exam for a nursing home client.

10-003.05J Mammograms: NMAP covers diagnostic and screening mammograms.

1. Screening Mammography: Screening mammograms are a preventive radiology procedure performed for early detection of breast cancer. NMAP covers one screening mammogram annually according to the periodicity schedule and guidelines of the American Cancer Society.
2. Diagnostic Mammography: Diagnostic mammograms are covered based on the medical necessity of the service (see 10-001.04, Medical Necessity).

Mammography services are covered only for providers who have met Medicare certification criteria for mammography services.

10-003.06 Therapeutic Services: Therapeutic services (physical, respiratory, occupational, speech, or psychological) which a hospital provides to an inpatient or outpatient are those services (including the use of the hospital facilities) which are incidental to the services of the physicians in the treatment of patients.

Covered therapeutic services to hospital inpatients/outpatients include the services of therapists and equipment necessary for therapeutic services.

10-003.07 Labor and Delivery: NMAP covers reasonable and necessary services associated with pregnancy. Medical care for pregnancy is reimbursable, beginning with diagnosis of the condition, continuing through delivery, and ending after the necessary postnatal care, or termination of pregnancy. After the infant is delivered, the infant is treated as a separate patient for reimbursement purposes.

NMAP covers routine prenatal care, delivery, six weeks post-partum care, and routine urinalysis as a package service for physicians. NMAP does not reimburse hospitals for any physicians' services included in the package service.

NMAP may cover hospital outpatient/emergency room services which meet the coverage criteria for medically necessary services which are not included in the physicians' package service.

If the patient is admitted as a registered inpatient with the expectation of remaining overnight, experiences false labor, and is released the same day before the census-taking hour, a day of inpatient maternity routine care is counted. If the patient is not admitted as an inpatient and receives care for less than 24 hours, the services are considered outpatient services. If the patient receives care for 24 or more continuous hours, the services are considered inpatient services regardless of the hour of admission or whether she remained in the hospital past midnight or the census-taking hour.

The Department utilizes the current Medicare methodology in accounting for labor/delivery charges on the Medicare cost report.

10-003.08 Operating Room: When a patient with a known diagnosis enters a hospital for a specific surgical procedure or other treatment that is expected to keep him/her in the hospital for less than 24 hours, and this expectation is realized, s/he will be considered an outpatient regardless of: the hour of admission; whether or not s/he used a bed; and whether or not s/he remained in the hospital past midnight. If the patient receives 24 or more hours of care, the patent is considered an inpatient regardless of the hour of admission or whether s/he remained in the hospital past midnight or the census-taking hour.

10-003.09 Other Ancillary Services

10-003.09A Emergency Room Physicians' Services: The hospital shall bill the Department for emergency room physicians' services on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the physician's provider number.

10-003.09B Medical Social Services: Medical social services are those social services which contribute meaningfully to the treatment of a patient's condition. These services include, but are not limited to -

1. Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the hospital;
2. Appropriate action to obtain case work services to assist in resolving problems in these areas; and
3. Assessment of the patient's medical and nursing requirements, his/her home situation, his/her financial resources, and the community resources available to him/her in making the decision regarding his/her discharge.

The cost of medical social services when provided to an inpatient is included in the hospital's payment for the inpatient service.

10-003.09C Dialysis Services: Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis procedures in common usage: hemodialysis and peritoneal dialysis. Both are acceptable modes for treatment of end stage renal disease.

10-003.09C1 Inpatient Dialysis Services: Dialysis services provided to an individual who is an inpatient are considered to be inpatient services. Payment for inpatient dialysis services is included in the hospital's payment for inpatient services. The hospital may include the costs of inpatient dialysis services on its cost report to be considered in calculating the hospital's payment rate.

10-003.09C2 Outpatient Dialysis Services: Outpatient dialysis services are those dialysis services provided to an individual who is an outpatient. Outpatient dialysis services must be provided by a Medicare certified renal dialysis facility. Outpatient dialysis services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Outpatient dialysis services are reimbursed at the provider's current Medicare composite rate for the services provided. Payment excludes the cost of physician services.

10-004 Non-Covered Services

10-004.01 Surgical Procedures: NMAP does not cover -

1. Acupuncture;
2. Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
3. Angiocardiography, utilizing CO_2 method, supervision and interpretation only;
4. Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
5. Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
6. Ballistocardiogram;
7. Basal metabolic rate (BMR);
8. Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
9. Circumcision, female;
10. Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
11. Extra-intra cranial arterial bypass for stroke;
12. Fabric wrapping of abdominal aneurysm;
13. Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
14. Fascia lata by stripper when used as a treatment for lower back pain;
15. Hypogastric or presacral neurectomy (independent procedure);
16. Hysterotomy, non-obstetrical, vaginal;
17. Icterus index;
18. Ileal bypass or any other intestinal surgery for the treatment of obesity;
19. Kidney decapsulation, unilateral and bilateral;
20. Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;
21. Ligation of internal mammary arteries, unilateral or bilateral;
22. Ligation of thyroid arteries (independent procedure);
23. Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;
24. Omentopexy for establishing collateral circulation in portal obstruction;
25. Perirenal insufflation;
26. Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
27. Protein bound iodine (PBI);
28. Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
29. Refractive keratoplasty (includes keratomileusis, keratophakia, and radial keratotomy);
30. Reversal of tubal ligation or vasectomy;

31. Sex change procedures;
32. Splanchicectomy, unilateral or bilateral, when used as a treatment for hypertension;
33. Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both;
34. Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension; and
35. Uterine suspension, with or without presacral sympathectomy.

10-004.02 Obsolete Tests: NMAP does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:

1. Amylase, blood isoenzymes, electrophoretic;
2. Chromium, blood;
3. Guanase, blood;
4. Zinc sulphate turbidity, blood;
5. Skin test, cat scratch fever;
6. Skin test, lymphopathia venereum;
7. Circulation time, one test;
8. Cephalin flocculation;
9. Congo red, blood;
10. Hormones, adrenocorticotropin quantitative animal tests;
11. Hormones, adrenocorticotropin quantitative bioassay;
12. Thymol turbidity, blood;
13. Skin test, actinomycosis;
14. Skin test, brucellosis;
15. Skin test, leptospirosis;
16. Skin test, psittacosis;
17. Skin test, trichinosis;
18. Calcium, feces, 24-hour quantitative;
19. Starch; feces, screening;
20. Chymotrypsin, duodenal contents;
21. Gastric analysis pepsin;
22. Gastric analysis, tubeless;
23. Calcium saturation clotting time;
24. Capillary fragility test (Rumpel-Leede);
25. Colloidal gold;
26. Bendien's test for cancer and tuberculosis;
27. Bolen's test for cancer; and
28. Rehfuss test for gastric acidity.

These tests may be covered only if the physician who performs the test justifies the medical necessity for the test. Medicaid Division staff shall determine that satisfactory medical necessity exists from the physician's justification.

10-004.03 Services Required to Treat Complications or Conditions Resulting from Non-Covered Services: The Department may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

Hospital inpatient or outpatient services are sometimes required to treat a condition that arises from services which NMAP does not cover. Payment may be made for services furnished under these circumstances if they are reasonable and necessary and meet coverage criteria for the service in all other respects.

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

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

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

10-004.04 Services Not Reasonable and Necessary: NMAP does not cover items and services which are not reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the function of a malformed body member.

10-004.05 Experimental and Investigational Services: Experimental or Investigational Services: NMAP does not cover medical services which are considered investigational and/or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, NMAP prohibits payment for these services.

Within this part, medical services include, but are not limited to, medical, surgical, diagnostic, mental health, substance abuse, or other health care technologies, supplies, treatments, procedures, drugs, therapies, and devices.

10-004.05A Related Services: NMAP does not pay for associated or adjunctive services that are directly related to non-covered experimental/investigational services (for example, laboratory services, radiological services, other diagnostic or treatment services, practitioner services, hospital services, etc.).

NMAP may cover complications of non-covered services once the non-covered service is completed (see 471 NAC 10-004.03).

10-004.05B Requests for NMAP Coverage: Requests for NMAP coverage for new services or those which may be considered experimental or investigational must be submitted before providing the services, or in the case of true medical emergencies, before submitting a claim. Requests for NMAP determinations for such coverage must be submitted in writing to the Department's Medical Director at the following address by mail or fax method:

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

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

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

1. There is no Food and Drug Administration (FDA) or other governmental/regulatory approval given, when appropriate, for general marketing to the public for the proposed use;
2. Reliable evidence does not permit a conclusion based on consensus that the service is a generally accepted standard of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease/proposed use and age group. Also, facility specific data, including short and long term outcomes, must be submitted to the Department;
3. The service is available only through an Institutional Review Board (IRB) research protocol for the proposed use or subject to such an IRB process; or
4. The service is the subject of an ongoing clinical trial(s) that meets the definition of a Phase I, Phase II, or Phase III Clinical Trial, regardless of whether the trial is actually subject to FDA oversight and regardless of whether an IRB process/protocol is required at any one particular institution.

10-004.05C Definition of Clinical Trials: For services not subject to FDA approval, the following definitions apply:

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

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

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

10-004.06 Autopsies: Autopsies are a non-covered service under Medicaid.

10-004.07 Custodial or Respite Care: Medicaid does not cover hospital services that are custodial or respite care.

10-004.08 Facility Based Physician Clinics: Physician Clinic services provided in a hospital location or a facility under the hospital's licensure are considered content of the physician service, not outpatient hospital services. Physician clinic services are defined as the professional activity, any drugs and supplies used during that professional encounter and any other billable service provided in the physician clinic area.

1. Nebraska Medicaid does not recognize facility/hospital based non-emergency physician clinics for billing, reimbursement or cost reporting purposes except for itinerant physicians as defined in 471 NAC 18-004.41/10-005.21.
2. Services and supplies incident to a physician's professional service provided during a specific encounter are covered and reimbursed as physician clinic services if the service or supply is:
   a. Of the type commonly furnished in a physician's office;
   b. Furnished as an incidental, although integral, part of the physician professional services; and
   c. Furnished under the direct personal supervision of the physician.
3. The Physician's clinic services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-004.09 Tobacco Cessation Services: Tobacco cessation services are not covered as a hospital service. Please see 471 NAC 16-000, Pharmacy Services and 471 NAC 18-000, Physicians' Services for coverage information.

10-004.10 Hospital Acquired Conditions: Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that Medicaid will, at a minimum, identify as an HAC, those diagnoses codes that have been identified as Medicare HACs when not present on hospital admission.

10-004.11 Health Care-Acquired Conditions: A health care-acquired condition (HCAC) means a condition occurring in any inpatient hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients.

10-005 Limitations and Requirements for Certain Services

10-005.01 Prior Authorization: NMAP requires that physicians request prior authorization from the Division of Medicaid and Long-Term Care before providing -

1. Medical transplants as follows:
   a. Heart transplants;
   b. Kidney transplants;
   c. Bone marrow transplants (allogenic and autologous); and
   d. Liver transplants;
2. Abortions;
3. Cosmetic and reconstructive surgery;
4. Gastric bypass surgery for obesity which includes the following procedures:
   a. Gastric bypass;
   b. Gastric stapling; and
   c. Vertical banded gastroplasty;
5. Out-of-State Services. Exception: Prior authorization is not required for emergency services;
6. Established procedures of questionable current usefulness;
7. Procedures which tend to be redundant when performed in combination with other procedures;
8. New procedures of unproven value;
9. Certain drug products, as specified in 471 NAC 10-005.01D; and
10. All non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans. See 471 NAC 18-004.30A.

10-005.01A Prior Authorization Procedures: The physician must request prior authorization for these services in writing or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50) prior to providing the service. See 471 NAC 10-001.02B1 for prior authorization/referral management for NMMCP.

10-005.01A1 Request for Additional Evaluations: NMAP must request additional evaluations when the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

10-005.01A2 Prior Authorization Approval/Denial Process: The prior authorization request review and determination must be completed by one or all of the following Department representatives:

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

10-005.01A3 Notification Process: Upon determination of approval or denial, the Department must send a written response to the following as applicable to the request:

1. Physician(s) submitting or contributing to the request;
2. Caseworker; and
3. Medical Review Organization when appropriate.

10-005.01B Verbal Authorization Procedures: NMAP may issue a verbal authorization when circumstances are of an emergency nature or urgent to the extent that a delay would place the client at risk of receiving medical care. When a verbal authorization is granted, a written request or electronic request using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) must be submitted within 14 days of the verbal authorization. A written or electronic response from the Department will be issued upon completion of the review.

10-005.01C Billing and Payment Requirements: Claims submitted to NMAP for services defined as requiring prior authorization will not be paid without written or electronic approval from the Department. A copy of the approval letter or notification of authorization issued by the Department must be submitted with all claims related to the procedure or service authorized.

Note: For dental services provided in a hospital (inpatient or outpatient), the dentist must request prior authorization of payment for the dental procedure from the Division of Medicaid and Long-Term Care (also see 471 NAC 6-000). Hospital outpatient services for dental procedures must be prior authorized by the Division of Medicaid and Long-Term Care.

10-005.01D Drug Products that Require Prior Approval: The following prescribed products require prior approval:

1. Sunscreens (Examples: Presun 29, Solbar-50);
2. Certain modified versions, combinations, double-strength entities, or products considered by the Department to be equivalent to drug products contained on the state maximum allowable cost or federal upper limit listings (Examples: Libritabs, Keftabs);
3. Human Growth Hormone;
4. Erythropoietin (Examples: Epogen, Procrit);
5. Drugs or supplies intended for convenience use (Examples: Refresh Ophthalmic 0.3 ml; Novolin penfil insulin);
6. Drugs used for prevention of infection with respiratory syncytial virus (e.g., respiratory syncytial virus immune globulin, palivizumab);
7. Certain drugs or classes of drugs used for gastrointestinal disorders, including but not limited to hyperacidity, gastroesophogeal reflux disease, ulcers, or dyspepsia (examples: omeprazole, famotidine);
8. Certain drugs or classes of drugs used for relief of pain, discomfort associated with musculoskeletal conditions, inflammation or fever (examples: butorphanol, carisoprodol, tramadol);
9. Certain drugs or classes of drugs used for relief of cough and/or symptoms of the common cold, influenza, or allergic conditions (examples: loratadine, zanimivir, oseltamivir);
10. Certain drugs or classes of drugs that are used for non-covered services or indications (see 471 NAC 16-003 Non-Covered Services) and for covered services or indications (example: orlistat, sildenafil);
11. Certain drugs or classes of drugs on the state maximum allowable cost or federal upper limit listings;
12. Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins;
13. Certain drugs or classes of drugs that are used for tobacco cessation; and
14. Certain drugs or classes of drugs that are determined by the Pharmaceutical and Therapeutics Committee to not be placed onto the Preferred Drug List.

Identifiable products requiring approval prior to payment are designated as such on the NE-POP System or on the Department's website.

The Department requires that authorization be granted prior to payment for certain drugs or items. Physicians who are prescribing these drugs or pharmacists who are dispensing these drugs must obtain prior authorization by submitting the request either by standard electronic transaction or by phone, fax, or mail from either:

1. The Department's NE-POP contractor; or
2. The Pharmacy Consultant (or designee)

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
P. O. Box 95026
301 Centennial Mall South, 5th Floor
Lincoln, NE 68509
Phone: (877) 255-3092
Fax: 402-471-9092
E-Fax: (402) 742-2348

10-005.02 Hospital Admission Diagnostic Procedures: The major factors which are considered to determine that a diagnostic procedure performed as part of the admitting procedure to a hospital is reasonable and medically necessary are -

1. The test is specifically ordered by the admitting physician, or a hospital staff physician responsible for the patient when there is no admitting physician (i.e., the test is not provided on the standing orders of a physician for all his/her patients);
2. The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and
3. The test does not unnecessarily duplicate the same test performed on an outpatient basis before admission or performed in connection with a recent hospital admission.

10-005.03 HIV Testing for Acquired Immune Deficiency Syndrome: NMAP payment for HIV testing is limited to medical necessity. Medical necessity for HIV testing exists if the individual has a known risk for exposure to HIV defined as follows:

1. All men who have engaged in unprotected sexual risk behaviors with another man since 1977;
2. Persons sharing contaminated hypodermic needles for intravenous drug use or other purposes since 1977;
3. Persons who have received blood or blood products between 1977-1985, especially persons with hemophilia (excluding at this time all immune serum globulin and heat-tested products, and Hepatitis B vaccine);
4. Persons who have exchanged sex for drugs or money since 1977;
5. Persons who have engaged in unprotected risk behaviors with someone who has AIDS or a known HIV-related condition or infection, or who is at increased risk or exposure to HIV:
6. Infants born to mothers infected with HIV; and
7. Persons who have engaged in unprotected sexual risk behaviors with multiple partners.

10-005.03A Non-Covered HIV Testing: NMAP does not pay for HIV testing when there is no history of risk as defined in 471 NAC 10-005.03. This includes, but is not limited to, the following:

1. Routine prenatal screening;
2. Routine pre-operative testing;
3. Educational or employment requirements;
4. Entrance requirements for the armed services; and
5. Insurance applications.

10-005.03B Informed Consent For HIV Testing (Reserved)

10-005.04 Minor Surgical Procedures: Reimbursement for excision of lesions of the skin or subcutaneous tissues include all services and supplies necessary to provide the service. NMAP does not make additional reimbursement for suture removal to the physician who performed the initial service or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the physician who provided the initial service, NMAP may approve separate payment for the suture removal.

10-005.05 Treatment for Obesity: NMAP will not make payment for services provided when the sole diagnosis is "obesity".

Obesity itself cannot be considered an illness. The immediate cause is a caloric intake which is persistently higher than caloric output. When obesity is the only diagnosis, treatment cannot be considered reasonable and necessary for the diagnosis or treatment of an illness or injury.

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

10-005.05A Intestinal By-Pass Surgery: The safety of intestinal by-pass surgery for the treatment of obesity has not been demonstrated. Severe adverse reactions such as steatorrhea, electrolyte depletion, liver failure, arthralgia, hypoplasia of bone marrow, and avitaminosis have sometimes occurred as a result of this procedure. NMAP does not consider this procedure to be reasonable and necessary, and does not cover the procedure.

10-005.05B Gastric By-Pass Surgery for Obesity: Gastric by-pass surgery for patients with extreme obesity may be covered when the surgery is -

1. Medically appropriate for the individual; and
2. Performed to correct an illness which caused the obesity or was aggravated by the obesity.

Physicians shall request prior authorization for gastric by-pass surgery prior to providing the service.

If approved, the provider shall submit a copy of the letter of authorization or notification of authorization with all claims for the service submitted to the Department.

10-005.06 Cosmetic and Reconstructive Surgery: NMAP covers cosmetic and reconstructive surgical procedures and medical services when medically necessary for the purpose of correcting the following conditions:

1. Limitations in movement of a body part caused by trauma or congenital conditions;
2. Disfiguring or painful scars in areas that are visible;
3. Congenital birth anomalies;
4. Post-mastectomy breast reconstruction; and
5. Other procedures determined to be restorative or necessary to correct a medical condition.

10-005.06A Exceptions: To determine the medical necessity of the condition, NMAP requires prior authorization for cosmetic and reconstructive surgical procedures except for the following conditions:

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

The surgeon who will be performing the cosmetic or reconstructive (C/R) surgery shall submit a written request or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50) for prior authorization before providing the service.

If approved, the provider shall submit a copy of the letter of authorization or notification of authorization with all claims for the service submitted to the Department.

10-005.07 Sterilizations

10-005.07A Age Requirement: The Nebraska Medical Assistance Program is prohibited from paying for sterilization of individuals -

1. Under the age of 21 on the date the client signs Form MMS-100; or
2. Legally incapable of consenting to sterilization.

10-005.07B Coverage Conditions: NMAP covers sterilizations only when -

1. The sterilization is performed because the client receiving the service made a voluntary request for services;
2. The client is advised at the outset and before the request or receipt of his/her consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized;
3. Clients whose primary language is other than English must be provided with the required elements for informed consent in their primary language.

10-005.07C Procedure for Obtaining Services: Non-therapeutic sterilizations are covered by NMAP only when -

1. Legally effective informed consent is obtained on Form MMS-100, "Consent Form" (see 471-000-109) from the client on whom the sterilization is to be performed. The surgeon shall submit a properly completed and legible Form MMS-100 to the Department before payment of claims can be considered; and
2. The sterilization is performed at least 30 days following the date informed consent was given. To calculate this time period, day 1 is the first day following the date on which the form is signed by the client. Day 31 in this period is the first day on which the procedure could be covered by NMAP. The consent is effective for 180 days from the date Form MMS-100 is signed. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since s/he signed the informed consent for the sterilization. For a premature delivery, the client must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MMS-100.

10-005.07D Informed Consent: Informed consent means the voluntary, knowing assent of the client who is to be sterilized after s/he has been given the following information:

1. A clear explanation of the procedures to be followed;
2. A description of the attendant discomforts and risks;
3. A description of the benefits to be expected;
4. Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;
5. An offer to answer any questions concerning the procedures; and
6. An instruction that the individual is free to withhold or withdraw his/her consent to the sterilization at any time before the sterilization without prejudicing his/her future care and without loss of other project or program benefits to which the client might otherwise be entitled.

This information is shown on Form MMS-100, which must be completed by the client.

10-005.07E Sterilization Consent Forms: Form MMS-100, "Sterilization Consent Form," (see 471-000-109) may be ordered by the physician directly from the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, or from the local HHS office. The surgeon shall submit a properly completed and legible Form MMS-100 to the Department before payment of claims can be considered.

10-005.08 Hysterectomies: NMAP covers hysterectomies when medically necessary. For payment of claims for hysterectomies (hospital, surgeon, assistant surgeon, anesthesiologist), the surgeon shall submit to the Department Form MMS-101, "Informed Consent Form," (see 471-000-110) properly signed and dated by the client in which she states that she was informed before the surgery was performed that this surgical procedure results in permanent sterility before claims associated with the hysterectomy can be considered.

Exception: NMAP does not require informed consent if -

1. The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was already sterile before the hysterectomy and states the cause of the sterility.
2. In the case of a post-menopausal woman, the Department considers the woman to be sterile. All claims related to the procedure must indicate that the client is post-menopausal.
3. The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which s/he determined prior acknowledgment was not possible. The physician must also include certification of the emergency.

A copy of the physician's certification regarding the above exceptions must be submitted to NMAP before consideration for payment for claims associated with the hysterectomy can be submitted.

10-005.08A Non-Covered Hysterectomies: NMAP shall not cover a hysterectomy if -

1. It was performed solely to make the woman sterile; or
2. If there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.

10-005.09 Abortions: NMAP covers medical procedures and abortions only when the life of the mother would be endangered if the fetus were carried to term. A physician shall certify the diagnosis by medical reports which include the name and address of the client. The treating physician shall request and receive prior authorization before providing the service from -

Medical Director
Medicaid Division
Nebraska Department of Health and Human Services
Finance and Support
301 Centennial Mall South, Fifth Floor
P.O. Box 95026
Lincoln, NE 68509

If approved, the Department sends a letter of authorization to the provider and retains one copy of the letter of authorization. In cases of documented emergencies, authorization may be requested after the service has been provided. All other requirements of this subsection must be met.

10-005.09A Required Forms: The provider shall submit a copy of the notification of authorization with all claims (surgeon, assistant surgeon, anesthesiologist, hospital) submitted for abortions to the Department.

10-005.10 Infertility: NMAP limits coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical problem, for example, thyroid disease, brain tumor, or hormone dysfunction. Reimbursement/coverage is not available when the sole purpose of the service is achieving a pregnancy.

10-005.11 (Reserved)

10-005.12 Alcohol and Chemical Detoxification: The Department limits payment for alcohol and chemical detoxification to medically necessary treatment, subject to the Department's utilization review.

This period includes an average detoxification period of two to three days with an occasional need for up to five days when the patient's condition dictates. A detoxification program for a particular patient may exceed five days and be covered if determined medically necessary by NMAP. The Department does not cover services when the detoxification needs of an individual no longer require an inpatient hospital setting.

10-005.13 Osteogenic Stimulation: Electrical stimulation to augment bone repair (osteogenic stimulation) can be performed either invasively or non-invasively.

10-005.13A Invasive Osteogenic Stimulation: Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. For percutaneously-placed cathodes, the power supply is externally placed and the leads connected to the inserted cathodes. For the implanted cathode, the power pack is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. NMAP covers use of the invasive device only for non-union of long bone fractures. NMAP considers non-union to exist only after six months or more have elapsed without the fracture healing.

10-005.13B Non-Invasive Osteogenic Stimulation: For the non-invasive device, opposing pads wired to an external power supply are placed over the cast. An electromagnetic field is created between the pads at the fracture site. NMAP covers use of the non-invasive device only for -

1. Non-union of long bone fractures;
2. Failed fusion; and
3. Congenital pseudoarthroses.

10-005.14 Biofeedback Therapy: Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Biofeedback therapy differs from electromyography, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. However, an electromyography device may be used to provide feedback with certain types of biofeedback.

Biofeedback therapy is covered under NMAP only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states, for psychosomatic conditions, or for psychiatric conditions.

10-005.15 Sleep Disorder Clinics: Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. NMAP covers diagnostic and therapeutic services of a sleep disorder clinic under the following conditions.

10-005.15A Diagnostic Services: All reasonable and necessary diagnostic tests given for the medical conditions listed in 471 NAC 10-005.15B are covered when the following criteria are met:

1. The clinic must be affiliated with a hospital;
2. Patients must be referred to the sleep disorder clinic by a physician. The clinic shall maintain a record of the attending physician's orders; and
3. The need for diagnostic testing must be confirmed by medical evidence, e.g., physician examinations and laboratory tests.

Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered.

10-005.15B Medical Conditions for Which Diagnostic Testing is Covered: Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the following conditions. Most patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over. The overnight stay is considered an integral part of these tests.

1. Narcolepsy: This term refers to a syndrome that is characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep. Related diagnostic testing is covered if the patient has inappropriate sleep episodes or attacks (e.g., while driving, in the middle of a meal, in the middle of a conversation), amnesiac episodes, or continuous disability drowsiness. The sleep disorder clinic shall submit documentation that this condition is severe enough to interfere with the patient's well-being and health before Medicaid benefits may be provided for diagnostic testing. A maximum of three "sleep naps" to confirm a diagnosis of narcolepsy may be covered.

2. Sleep Apnea: This is a potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described - central, obstructive, and mixed. The nature of the apnea episodes can be documented by appropriate diagnostic testing. A maximum of one night stay per patient is covered by NMAP.

10-005.15C Therapeutic Services: Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Although only the diagnostic services indicated above are covered under Medicaid, therapeutic services may be covered provided they are standard and accepted services and are reasonable and medically necessary for the patient. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services may be provided for -

1. Insomnia;
2. Nocturnal myoclonus (muscle jerks);
3. Sleep apnea (typically central type);
4. Drug dependency;
5. Shift work and schedule disturbances;
6. Restless leg syndrome;
7. Hypersomnia (excessive daytime sleepiness);
8. Somnambulism;
9. Night terrors or dream anxiety attacks;
10. Enuresis; and
11. Bruxism.

10-005.16 Portable X-Ray Services: NMAP covers diagnostic x-ray services provided by a certified portable x-ray provider when provided in a place of residence used as the patient's home and in nonparticipating institutions. These services must be performed under the general supervision of a physician and certain conditions relating to health and safety (see 471 NAC 10-005.16B) must be met.

NMAP also covers diagnostic portable x-ray services when provided in participating SNF's, under circumstances in which they cannot be covered as SNF services, i.e., the services are not provided by the participating institution either directly or under arrangements that allow the institution to bill for the services.

If portable x-ray services are provided in a participating hospital under arrangement, the hospital shall bill the Department for the service.

10-005.16A Certified Providers: To be approved as a provider under NMAP, providers of portable x-ray services must be certified by the CMS Regional Office.

For a Nebraska portable x-ray provider, the Division of Medicaid and Long-Term, Care staff must receive a copy of Form CMS-1539, "Medicare/Medicaid Certification and Transmittal" (see 471-000-66).

For an out-of-state portable x-ray provider, the Division of Medicaid and Long-Term Care shall request verification of certification from the CMS Regional Office. The Department approves or denies enrollment based on the certification information received from the CMS Regional Office.

The CMS Regional Office updates certification information and sends the information to the Department according to the federal time frame which is currently in effect for portable x-ray providers.

10-005.16B Applicability of Health and Safety Standards: The health and safety standards apply to all providers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services. Payment is made only for services of approved providers who have been found to meet the standards.

When the services of a provider of portable x-ray services no longer meet the conditions of coverage, physicians responsible for supervising the portable x-ray services and having an interest in the x-ray provider's certification status must be notified. The notification action regarding suppliers of portable x-ray equipment is the same as required for decertification of independent laboratories, and the same procedures are followed.

10-005.16C Covered Portable X-Ray Services: NMAP covers the following portable x-ray services:

1. Skeletal films involving arms and legs, pelvis, vertebral column, and skull;
2. Chest films which do not involve the use of contrast media (except, of course, routine screening procedures and tests in connection with routine physical examinations); and
3. Abdominal films which do not involve the use of contrast media.

10-005.16D Non-Covered Portable X-Ray Services: NMAP does not cover the following portable x-ray services:

1. Procedures involving fluoroscopy;
2. Procedures involving the use of contrast media;
3. Procedures requiring the administration of a substance to the patient or injection of a substance into the patient and/or special manipulation of the patient;
4. Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
5. Procedures requiring special technical competency and/or special equipment or materials;
6. Routine screening procedures; and
7. Procedures which are not of a diagnostic nature.

10-005.16E Billing Requirements: Claims for portable x-ray services must contain -

1. The name of the physician who ordered the service; and
2. The reason an x-ray test was required.

10-005.16F Electrocardiograms: The taking of an electrocardiogram tracing by an approved supplier of portable x-ray services may be covered as an "other diagnostic test." The health and safety standards in 471 NAC 10-005.16B must be met.

10-005.17 Durable Medical Equipment and Medical Supplies: NMAP does not generally approve hospitals as providers of durable medical equipment and medical supplies. Exception: Apnea monitors (see 471 NAC 10-005.22 ff.).

10-005.18 Hospital Dental Services: When dental treatment is necessary as a hospital inpatient or outpatient service, see 471 NAC 6-000.

10-005.19 Cardiac Stress Testing and Hospital Outpatient Cardiac Rehabilitation Programs: Stress testing is a covered diagnostic procedure for evaluating chest pain and as a component in the development of rehabilitation exercise prescriptions for the treatment of patients with known cardiac disease provided that during the testing -

1. A physician is present;
2. Emergency equipment is available; and
3. A standard emergency procedure plan is in effect.

When the testing is done in the hospital inpatient or outpatient setting, these conditions are presumed to exist absent evidence to the contrary. However, the use of stress testing in the absence of any specific diagnostic or therapeutic purpose, e.g., for purposes such as work evaluation or coronary risk factor profile evaluation, are not covered as reasonable and necessary to the treatment of the patient's condition.

Outpatient cardiac rehabilitation programs consisting of individually-prescribed physical exercise or conditioning and concurrent telemetric monitoring are considered a valuable therapeutic modality for increasing the functional capacity of the cardiorespiratory reserve in certain stabilized cardiac patients, e.g., patients who have had a myocardial infarction and have reached the point where they are considered ready to commence physical activity consistent with their particular condition. When a program is provided by a hospital to its outpatients, the service is covered as an outpatient service.

Hospital outpatient services in connection with a cardiac rehabilitation exercise program are considered reasonable and necessary only during that period of time when the patient's condition is such that the exercises can only be carried out safely under the direct, continuing supervision of a physician and in a hospital environment. No more than 12 weeks (or 36 sessions) of a monitored exercise program is generally necessary for most patients to reach an acceptable level of individual exercise tolerance consistent with the particular stage of their disease. By this time the patient in most cases is physically and psychologically prepared to continue his/her exercise program at home on his/her own. Claims for services beyond a maximum duration of 12 weeks (or 36 sessions) must be accompanied by documentation supporting the patient's need for additional services.

Documentation must include -

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

The monitoring required in these programs must be carried out by a hospital-employed nurse trained in cardiac rehabilitation, with a physician overseeing the monitoring. Although on occasion physical therapists and/or occupational therapists are involved in these programs, they generally act only as exercise leaders. These services do not constitute covered physical therapy or occupational therapy.

Since the type of cardiac rehabilitation exercise program which can be covered requires a hospital setting, this program is not covered in a skilled nursing facility.

10-005.20 Medical Transplants: NMAP covers transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the Medical Director of the Medicaid Division shall determine whether the transplant is medically necessary or non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance program covers liver or heart transplantation when the written opinions of two physicians specializing in transplantation state that a transplant is medically necessary as the only clinical practical, and viable alternative to prolong the patient's life in a meaningful, qualitative way and at a reasonable level of functioning.

NMAP is the payor of last resort.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 10-005.20D). An exception may be made for emergency situations, in which case verbal approval is obtained and the notification of authorization is sent later.

10-005.20A Services for an NMAP-Eligible Donor: NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 10-005.20D).

10-005.20B Services for an NMAP-Ineligible Donor: NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment for complications related to the donor is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are not directly related to the transplant.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 10-005.20D).

10-005.20C Billing for Services Provided to an NMAP-Ineligible Donor: Claims for services provided to an NMAP-ineligible donor must be submitted under the NMAP-eligible client's case number. There must be a notation on or in the claim that these services were provided to the NMAP-ineligible donor on the client's behalf.

10-005.20D Prior Authorization: Physicians shall request prior authorization before performing any transplant service or related donor service. This request for authorization must be submitted in writing or using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50) by the physician to -

The Medical Director
Medicaid Division
Nebraska Department of Health and Human Services Finance and Support
301 Centennial Mall South
P. O. Box 95026
Lincoln, Nebraska 68509

The request must include at a minimum -

1. The patient's name, age, diagnosis, pertinent past medical history and treatment to this point, prognosis with and without the transplant, and the procedure(s) for which the authorization is requested;
2. The patient's Nebraska Medicaid number;
3. Name of hospital, city, and state where the service(s) will be performed. The Department's policy regarding out-of-state services remains in effect. See 471 NAC 1-002.01F;
4. Name of physician(s) who will perform the surgery if other than physician requesting authorization; and
5. If authorization is requested for a liver or heart transplant, in addition to the above information, two physicians shall also supply the following:
   a. The screening criteria used in determining that a patient is an appropriate candidate for a liver or heart transplant;
   b. The results of that screening for this patient (i.e., the patient is eligible to be placed on "waiting list" in which the only remaining criteria is organ availability); and

c. A statement by each physician -
   (1) Recommending the transplant; and
   (2) Certifying and explaining why a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the client's life in a meaningful, qualitative way and at a reasonable level of functioning.

The Nebraska Department of Health and Human Services Finance and Support, Medical Director, shall send a response to the provider(s) advising them of the approval or denial of Medicaid payment of the requested transplant.

10-005.20E Payment for Liver or Heart Transplant Services: Only those services which are determined by the NMAP to be medically necessary and appropriate will be considered for Medicaid payment. The Department reserves the right to request any medical documentation from the patient's record to support and substantiate claims submitted to the Department for payment. These records may include but are not limited to office records, hospital progress notes, doctor's orders, nurses notes, consultative reports, hospital admission history and physical, and discharge summary.

10-005.20E1 Hospital Inpatient Services: Payment for hospital inpatient services is established under 471 NAC 10-010.03.

Procurement costs include removal of organ, transportation, and associated costs. These costs must be billed by the transplanting hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) and separately identified on the Medicare cost report. The hospital shall submit copies of the actual invoices for procurement costs, including transportation costs, on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

Payment of the technical component of inpatient laboratory and diagnostic and therapeutic radiology services is included in the hospital's payment for inpatient services.

10-005.20E2 Ambulatory Room and Board: The Department may cover ambulatory room and board services for liver or heart transplant patients (for the client and an attendant if necessary). All hospital outpatient charges associated with ambulatory stays are paid in accordance with 471 NAC 10-010.06 ff. Ambulatory room and board fees are paid using the appropriate HCPCS procedure codes. Also see 471 NAC 10-005.24 ff.

10-005.20E3 Hospital Outpatient Services: All services not provided on an inpatient basis will be paid at the rates established under NMAP. For laboratory and radiology services, see the elimination of combined billing regulations at 471 NAC 10-003.05C ff. Outpatient clinical laboratory services must be itemized using the appropriate HCPCS procedure code (see 471 NAC 10-010.06 ff.).

10-005.20E4 Physician Services: Surgeon(s) services will be paid according to the Nebraska Medicaid Practitioner Fee Schedule. This fee will include two weeks' routine post-operative care by the designated primary surgeon. Payment for routine post-operative care will not be made to other members of the surgical team.

Physician services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-005.21 Itinerant Physician Visits: NMAP covers non-emergency physician visits provided in a hospital outpatient setting if the services are -

1. Provided by an out-of-town specialist who has a contractual agreement with the hospital. NMAP does not consider general practitioners or family practitioners to be specialists; and
2. Determined to have been provided in the most appropriate place of service (see 471 NAC 10-010.09A).

The hospital room charge is considered the technical component of the visit and must be billed on Form CMS-1450 (UB-92) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The physician's service must be coded as an office visit and billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The physician will be paid at the rate for the appropriate level of office visit.

10-005.22 Infant Apnea Monitors: NMAP covers rental of home infant apnea monitors for infants with medical conditions that require monitoring due to a specific medical diagnosis only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent/caregiver training must occur before placement of infant apnea monitor. Parent/caregiver training is not reimbursed as a service separate from infant apnea monitor rental.

10-005.22A Medical Guidelines for the Placement of Home Infant Apnea Monitors: NMAP covers home infant apnea monitoring services for infants who meet one of the following criteria. NMAP defines infancy as birth through completion of one year of age.

1. Infants with one or more apparent life-threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking, or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hypoventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants of substance-abusing mothers, or infants with less severe ALTE's.

10-005.22A1 Removing the Infant from the Monitor: Criteria for removing infants from home infant apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when ALTE infants have had two-three months free of significant alarms or apnea where vigorous stimulation or resuscitation was not needed. Evaluating the infant's ability to tolerate stress (e.g., immunizations, illness) during this time is advisable.

The provider shall state the date of removal of the infant monitor on or in the final claim.

10-005.22B Approval of Home Infant Apnea Monitor Service Providers: NMAP covers rental of home infant apnea monitors and related supplies provided only by approved providers.

To ensure all home apnea monitoring needs of infants are met, the Department requires the development of a home infant apnea monitor "Coordination Plan." The "Coordination Plan" is not an individual patient plan; it is an overall program outline for the delivery of home apnea monitoring services. See 471 NAC 10-005.24, Coordination Plan Requirement for Certain Services.

10-005.22C Documentation Required After Initial Rental Period: Monitor rental exceeding the original two-month prescription period requires that an updated physician's narrative report of patient progress and a statement of continued need accompany the claim. A new progress report is required every two months. The report must include -

1. The number of apnea episodes during the previous prescription period;
2. The results of any tests performed during the previous prescription period;
3. Additional length of time needed; and
4. Any additional information the physician may wish to provide.

10-005.22D Limitations on Coverage of Apnea Monitor Equipment and Supplies: NMAP does not cover monitors that do not use rechargeable batteries.

NMAP does not make separate payment for remote alarms. If provided, payment for a remote alarm is included in the monitor rental.

Apnea monitor belts, lead wires, and reusable electrodes are covered for rented apnea monitors.

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

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

10-005.22D1 Pneumocardiograms: Pneumocardiograms are covered for diagnostic/evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation. This service must be billed by the physician performing the service.

10-005.22E Appropriate Hospital Services: Appropriate home infant apnea monitor services provided by a hospital with an approved infant apnea monitor "Coordination Plan" include rental of the apnea monitor, trend event recorder, and ECG/respirator recorder; purchase of related supplies; conversion of cassette recording to tape for interpretation; and CO_2/hypoxia studies.

Payment for hospital apnea monitoring services provided to an inpatient is included in the hospital payment for inpatient services. Outpatient services and supplies provided by the hospital must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as hospital outpatient services.

10-005.22F Billing: The hospital shall bill for the technical component of infant apnea monitor services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). See 471 NAC 10-010.06 ff. The provider of the apnea monitor shall state the date of removal of the infant monitor on the claim.

Physicians' services must be billed as professional services on a CMS-1500 Form or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

10-005.23 Home Phototherapy: NMAP covers rental of home phototherapy (bilirubin) equipment for infants that require phototherapy when neonatal hyperbilirubinemia is the infant's sole clinical problem when prescribed by and used under the supervision of a physician.

10-005.23A Medical Guidelines for the Placement of Home Phototherapy Equipment: NMAP recognizes the Nebraska Chapter of the American Academy of Pediatric's Standard of Care for home phototherapy. Home phototherapy services will be covered when the following conditions are met:

1. Neonatal hyperbilirubinemia is the infant's sole clinical problem;
2. The infant is greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gm (5 lbs);
3. The infant is greater than 48 hours of age;
4. Bilirubin level at initiation of phototherapy (greater than 48 hours of age) is 14-18 mgs per deciliter; and
5. Direct bilirubin level is less than 2 mgs per deciliter.

Home phototherapy is not covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.

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

1. History and physical assessment by the infant's attending physician has occurred. If home phototherapy begins immediately upon discharge from the hospital, the newborn discharge exam will suffice;
2. Required laboratory studies have been performed, including, CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin;
3. The physician certifies that the parent/caregiver is capable of administering home phototherapy;
4. Parent/caregiver have successfully completed training on use of the equipment; and
5. Equipment must be delivered and set up within 4 hours of discharge from the hospital or notification of provider, whichever is more appropriate. There must be a 24-hour per day repair and/or replacement service available.

At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

10-005.23B Discontinuing Home Phototherapy: Home phototherapy services will not be covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.

10-005.23C Approval of Home Phototherapy Providers: NMAP covers rental of home phototherapy equipment provided by approved providers. Physicians will not be approved as home phototherapy providers.

To ensure that home phototherapy needs of infants are met, the Department requires the development of a "Coordination Plan". The "Coordination Plan" is not an individual patient plan; it is an overall program outline for the delivery of home phototherapy services. See 471 NAC 10-005.24, Coordination Plan Requirement for Certain Services.

10-005.23D Documentation Required after Initial Rental Period: Home phototherapy services exceeding a three-day period require a physician's narrative report of patient progress and statement of continued need submitted with the claim.

10-005.23E Limitations on Coverage of Home Phototherapy Services: Services will be reimbursed on a daily basis. NMAP's daily allowable fee includes -

1. Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
2. A minimum of one daily visit to the home by a licensed and/or certified "health care professional" as identified by the supplier in the "Coordination Plan" (see 471 NAC 7-006). The daily visits must include -
   a. A brief home assessment; and
   b. Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available.

   An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill NMAP directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home.
3. Complete caregiver training on use of equipment and completion of necessary records.

Payment for home phototherapy services does not include physician's professional services or laboratory and radiology services related to home phototherapy. These services must be billed by the physician or laboratory performing the service.

10-005.23F Billing for Home Phototherapy Services: Hospitals shall bill home phototherapy services in a summary bill format on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as outpatient services.

10-005.24 "Coordination Plan" Requirement for Certain Services: A "Coordination Plan" is an overall program outline for the delivery of a specific service; it is not an individual patient care plan. The following services will be reimbursed only to hospital providers with HHS F&S approved "Coordination Plans"-

1. Apnea monitoring services; and
2. Phototherapy services.

A separate "Coordination Plan" is required for each type of service provided. The "Coordination Plan" must be submitted to and approved by the Medicaid Division prior to providing the service and must include -

1. A request for review of the "Coordination Plan" which includes the provider's name, address, phone number, contact person, and Medicaid provider number;
2. An overview of the services provided, including the provider's charge for the services;

3. Descriptions and literature on the equipment and all supplies and accessories provided;
4. Copies of all forms instructions, and record sheets for client use;
5. An outline of the training format used to train client on use of equipment and other training requirements (e.g., infant stimulation/resuscitation for apnea monitoring services);
6. The type and frequency of client contact (home visits, assessments, consultations, telephone follow-up, etc.) and identification and qualifications of personnel conducting client contacts; and
7. A statement of the provider's policy on equipment set-up, servicing, and availability for consultation on equipment problems.

After review of the "Coordination Plan, Medicaid Division staff shall notify the provider in writing of the "Coordination Plan" approval or disapproval.

The provider must notify the Medicaid Division of any changes in the "Coordination Plan".

10-005.25 Ambulatory Room and Board (Meals and Lodging): NMAP covers ambulatory room and board as a related transportation expense. NMAP covers ambulatory room and board only when the client is receiving NMAP coverable services and the following guidelines are met.

10-005.25A Definitions: The following definitions apply to ambulatory room and board services:

Ambulatory Room and Board Services: Meals and/or lodging determined to be necessary to secure NMAP coverable services, including medical examinations and treatment, for a client.

Attendant: A person who accompanies the client when the client is physically or mentally unable to travel or wait alone, including a child's parent or guardian.

10-005.25B Approval as an Ambulatory Room and Board Provider: NMAP approves only hospitals as ambulatory room and board providers. To receive NMAP payment, each hospital providing ambulatory room and board services must be enrolled with NMAP as a provider for hospital services and must submit Form MS-6, "Ambulatory Room and Board Agreement," (see 471-000-73) to -

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

The Department may request additional information from the hospital to approve ambulatory room and board services. After review, Medicaid staff shall notify each hospital of the decision regarding provider approval for ambulatory room and board services.

10-005.25C Provider Re-Approval: Each hospital approved by the Department to provide ambulatory room and board services shall seek re-approval of its ambulatory room and board services from the Department when any of the following occur:

1. The charge to the Department for ambulatory room and board services changes;
2. There is a change in the physical location of the ambulatory room and board facility or the distance from the hospital building;
3. There is a change in the services the hospital is able to provide to clients in the ambulatory room and board facility; or
4. Other substantial changes are made to the hospital's ambulatory room and board services.

10-005.25D Guidelines: NMAP covers ambulatory room and board services as follows:

1. Ambulatory room and board services must be necessary to secure NMAP coverable services, including medical examinations and/or treatment.
2. NMAP covers meals when receipt of NMAP coverable services requires the client to be away from his/her home for 12 hours or longer;
3. NMAP covers lodging when an out-of-town overnight stay is necessary while receiving NMAP coverable services or if coverage of ambulatory room and board services will prevent a hospital inpatient stay; and
4. NMAP covers meals and lodging for up to one day before or after receiving services if extensive travel is necessary.

Payment for ambulatory room and board services outside these guidelines must be approved by the Medicaid staff.

10-005.25E Billing and Payment: The hospital shall bill for ambulatory room and board services provided by a Department-enrolled hospital as an outpatient service on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using revenue code "995" and the appropriate HCPCS procedure codes.

Payment will be made using a hospital-specific rate. Payment to the hospital must not exceed its charge for services provided to the general public.

10-005.25F Documentation: The hospital must include a statement that documents the necessity for ambulatory room and board services for a client or for a client and an attendant on the hospital claim (see Claim Submission Table at 471-000-49.)

10-005.26 (Reserved)

10-005.27 Covered Services – Physical Therapy, Occupational Therapy, and Speech Pathology Services: Medicaid covers physical therapy, occupational therapy, and speech pathology services when the following criteria are met:

1. The services were ordered by a licensed physician;
2. The services are medically necessary;
3. The services are such a level of complexity and sophistication or the condition of the patient is such that only a qualified therapist can safely and effectively provide the service; and
4. The therapy service meets at least one of the conditions listed in 471 NAC 10-005.27A or 10-005.27B.

10-005.27A Services for Individuals Age 21 and Older: Medicaid covers a combined maximum total of 60 sessions per fiscal year (physical therapy, occupational therapy, and speech pathology services) for individual age 21 and older. The therapy services must be:

1. An evaluation; or
2. Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly within a reasonable period of time; or
3. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c, DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

10-005.27B Services for Individuals Age 20 and Younger: NMAP covers physical therapy, occupational therapy, and speech pathology services for individuals birth to age 20. The service must be:

1. An evaluation; or
2. Reasonable and medically necessary for the treatment of the client's illness or injury; or
3. Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly with in a reasonable period of time; or
4. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

10-005.27C Non-Covered Physical Therapy, Occupational Therapy, and Speech Pathology Services: NMAP does not cover therapy services in the following situations:

1. Clients Age 21 and Older – therapy sessions in excess of 60 sessions per fiscal year for any combination of physical therapy, occupational therapy, and speech therapy;
2. Therapy for vocational and prevocational assessment and training;
3. Therapy for functional capacity evaluations, educational testing, drivers training, or training in non-essential self-help or recreational activities (e.g. homemaking, cooking, finance), therapy related visual perception training, or for treatment of psychological conditions;
4. Therapy for dysfunctions that are self-correcting, such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting;
5. Therapy for delays in speech development that are not due to a specific disease or brain injury; or
6. Therapy for the following condition or diagnosis categories:
   a. Psychosocial speech delay;
   b. Behavior problems;
   c. Attention disorders;
   d. Conceptual handicap; or
   e. Learning disability.

10-006 through 10-009 (Reserved)

10-010 Payment for Hospital Services

10-010.01 (Reserved)

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for the Nebraska Medical Assistance Program excluding Nebraska Medicaid Managed Care Program's capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. Specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. Provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. Takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective using methods established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

Each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio.

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

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

APR-DRG: The All-Patient Refined Diagnosis-Related Group software application that assigns patients into categories based on severity of illness and risk of mortality.

Base Year: The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in 471 NAC 10-010.03B5 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital licensed as a Critical Access Hospital by the Department of Health and Human Services under 175 NAC 9 and certified for participation by Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, birth weight, procedure coding, comorbidity, and complications.

Direct Medical Education Cost Payment: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.

Disproportionate Share Hospital (DSH): A hospital located in Nebraska is deemed to be a disproportionate share hospital by having -

1. A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
2. A low-income utilization rate of 25 percent or more.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

DRG Weight: A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each DRG and Severity of Illness (SOI).

Health Care-Acquired Conditions: A health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Hospital-Acquired Condition: A condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission.

Hospital Mergers: Hospitals that have combined into a single corporate entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

Hospital-Specific Base Year Operating Cost: Hospital-specific operating allowable cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Hospital-Specific Cost-to-Charge Ratio: Hospital-Specific Cost-to-Charge Ratio is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-Specific Cost-to-Charge Ratios used for outlier cost payments and Transplant DRG CCR payments are derived from the outlier CCRs in the Medicare inpatient prospective payment system.

Indirect Medical Education Cost Payment: Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education payments.

Low-Income Utilization Rate: For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum (expressed as a percentage) of the fractions, calculated from acceptable data submitted by the hospital as follows:

1. Total Medicaid inpatient revenues (excluding payments for disproportionate share hospitals) paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals) in the same cost reporting period; and
2. The total amount of the hospital's charges for hospital inpatient services attributable to uncompensated care in ending in the calendar year preceding the Medicaid rate period, less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to uncompensated care does not include contractual allowances and discounts (other than for uncompensated care for patients not eligible for Medicaid), that is, reductions in charges given to other third-party payors, such as HMO's, Medicare, or Blue Cross.

Medicaid Allowable Inpatient Charges: Total claim submitted charges less claim non-allowable amount.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.

Medicaid Inpatient Utilization Rate: The ratio of (1) allowable Medicaid inpatient days, as determined by NMAP, to (2) total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out-of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

Medicaid Rate Period: The period of July 1 through the following June 30.

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

Medicare Cost Report: The report filed by each facility with its Medicare intermediary.

The Medicare cost report is available through the National Technical Information Service at the following address:

U.S. Department of Commerce
Technology Administration
National Technical Information Service
Springfield, VA 22161

A hospital that does not participate in the Medicare program shall complete the Medicare Cost Report in compliance with Medicare principles and supporting rules, regulations, and statutes (i.e., the provider shall complete the Medicare cost report as though it was participating in Medicare).

The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees (see 471 NAC 10-010.03S). Note: If a nursing facility (NF) is affiliated with the hospital, the NF cost report must be filed according to 471 NAC 12-011 ff. Note specifically that time guidelines for filing NF cost reports differ from those for hospitals.

New Operational Facility: A facility providing inpatient hospital care which meets one of the following criteria:

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

2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.
   Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Other Provider-Preventable Conditions (OPPC): A wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group except Peer Group 5 and Peer Group 6.

Present on Admission (POA) Indicator: A status code the hospital uses on an inpatient claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs.

Provider-Preventable Conditions (PPC): An umbrella term which is defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

Reporting Period: Same reporting period as that used for its Medicare cost report.

Resource Intensity: The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

Risk of Mortality (ROM): The likelihood of dying.

Severity of Illness Level (SOI): The extent of physiologic decompensation or organ system loss of function.

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

Uncompensated Care: Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

10-010.03B Payment for Peer Groups 1, 2, and 3 (Metro Acute, Other Urban Acute, and Rural Acute): Payments for acute care services are made on a prospective per discharge basis, except hospitals certified as a Critical Access Hospital.

For inpatient services, the total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
    a. Direct Medical Education Cost Payment;
    b. Indirect Medical Education Cost Payment; and
    c. A Cost Outlier Payment.

For inpatient services that are classified into a transplant DRG, the total per discharge payment is the sum of -

1. The Cost-to-Charge Ratio (CCR) Payment amount; and
2. When applicable - Direct Medical Education Cost Payment.

10-010.03B1 Determination of Operating Cost Payment Amount: The hospital DRG operating cost payment amount for discharges that are classified into a DRG is calculated by multiplying the peer group base payment amount by the applicable national relative weight.

10-010.03B1a Calculation of the APR-DRG Weights: For dates of service on and after July 1, 2014, the Department will use the All-Patient Refined Diagnosis Related Groups (APR-DRG) national relative weights to determine DRG classifications. The national weights are based on 3M's APR-DRG standard national weights. The Department will annually update the APR-DRG grouper and national relative weights with the most currently available version.

10-010.03B1b Calculation of the Starting Point for the Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges for non-transplant DRG. For purpose of rate setting, the starting point shall be the Medicaid Peer Group Base Payment Amount effective on July 1 of state fiscal year (SFY) 2011.

SFY 2010 Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B1b in effect July 1, 2010. For the purpose of maintaining budget neutrality with the APR-DRG grouper system, the state fiscal year (SFY) 2011 Peer Group Base Rates will be increased by 61.05 percent.

10-010.03B1b(1) Adjustment Based on Legislative Appropriations: The starting point for the peer group base payment amounts, as determined in section 10-010.03B1b, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The Peer Group Base Payment Amounts are adjusted annually and shall be effective each July 1.

10-010.03B2 Calculation of DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a DRG meeting or exceeding Medicaid criteria for cost outliers for each DRG classification. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $30,000 for all neonate and nervous system APR-DRGs at severity level 3 and severity level 4.

For all other APR-DRGs, the outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $51,800. Cost of the discharge is calculated by multiplying the Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is 80 percent of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85 percent of the difference between the hospital's cost for the discharge and the outlier threshold.

10-010.03B2a Hospital Specific Medicare Outlier CCRs: The Department will extract from the CMS PPS Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier CCRs effective October 1 of the year preceding the start of the Nebraska rate year.

10-010.03B2b Outlier CCRs Updates: On July 1 of each year, the Department will update the outlier CCRs based on the Medicare outlier CCRs effective October 1 of the previous year.

10-010.03B3 Calculation of Medical Education Costs:

10-010.03B3a Calculation of Direct Medical Education Cost Payments:

Direct Medical Education (DME) payments are based on Nebraska hospital-specific DME payment rates effective during SFY 2010.

SFY 2010 Nebraska hospital-specific DME payment rates are described in 471 NAC 10-010.03B in effect July 1, 2010. Each SFY Nebraska hospital-specific DME payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The DME payment rates are adjusted annually and shall be effective each July 1.

On July 1st of each year, the Department will update DME payment rates by replacing each hospital's intern and resident FTEs with each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1 of the previous year.

10-010.03B3b Calculation of Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from the Department, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the operating cost payment amount.

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program using the following formula:

$$[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1] * 1.35$$

On July 1 of each year, the Department will adopt the Medicare inpatient prospective payment system operating IME factor formulas and rate components in effect on October 1 of the previous year.

10-010.03B3c Calculation of Managed Care Organization (MCO) Medical Education Payments: The Department will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by capitated plans from discharge data provided by the plans.

1. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the fee-for-service direct medical education payment per discharge.

2. MCO Indirect Medical Education payments will be equal to the fee-for-service IME operating factor multiplied by the MCO operating payments.

10-010.03B4 Calculation of Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of stay for the DRG. Capital-related payment per diem amounts are calculated for Peer Group 1, 2, and 3 hospitals based on the Capital-related payment per diem amounts effective during SFY 2010.

The Base Capital-Related Cost Payments per diem amounts are described in 10-010.03B4 in effect on July 1, 2010. Each SFY the peer group specific capital-related payment per diem amounts shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The capital-related payment rates are adjusted annually and shall be effective each July 1.

10-010.03B5 (Reserved)

10-010.03B6 Transplant DRG Payments: Transplant discharges, identified as discharges that are classified to a transplant DRG, are paid a Transplant DRG CCR payment and, if applicable, a DME payment. Transplant DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B6a Transplant DRG CCR Payments: are calculated by multiplying the hospital-specific Transplant DRG CCR by Medicaid allowed claim charges.

On July 1 of each year, the Department will update the Transplant DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years.

Each SFY Nebraska hospital-specific transplant DRG CCR payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

10-010.03B6b Transplant DRG DME Payments: Transplant DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation.

On July 1 of each year, the Department will update Transplant DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.

10-010.03B7 (Reserved)

10-010.03B8 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1, 2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services shall not exceed 110 percent of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B8a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A final reconciliation will be made within 6 months following receipt by the Department of the facility's settled cost report.

Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110 percent of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B9 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

10-010.03B10 Inpatient Admission After Outpatient Services: Effective January 1, 2002 and after, a patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. Inpatient services, for billing and payment purposes, includes nonphysician outpatient services rendered on the day of admission or during the inpatient stay, diagnostic services rendered up to three days before the day of admission, and admission related nondiagnostic services rendered up to 3 days before the day of admission. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

10-010.03B11 Readmissions: NMAP adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All NMAP patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

10-010.03B12 Interim Payment for Long-Stay Patients: NMAP's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days.

To request an interim payment, the hospital shall send the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to the Department of Health and Human Services, Division of Medicaid and Long-Term Care.

The hospital will be notified in writing if the request for interim payment is denied.

10-010.03B12a Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement "from" and "to" dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

10-010.03B13 Payment for Non-physician Anesthetist (CRNA) Fees: Hospitals which meet the Medicare exception for payment of CRNA fees as a pass-through by Medicare will be paid for CRNA fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for CRNA services. Costs will be calculated using the hospital's specific anesthesia cost to charge ratio. CRNA fees must be billed using revenue code 964 - Professional Fees Anesthetist (CRNA) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

10-010.03C Non-Payment for Hospital Acquired Conditions: NMAP will not make payment for those claims which are identified as non-payable by Medicare as a result of avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This provision applies only to those claims in which Medicaid is a secondary payor to Medicare.

10-010.03D Payments for Psychiatric Services: Payments for psychiatric discharges are made on a prospective per diem.

Tiered rates will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission, but not the day of discharge.

Mental health and substance abuse services provided to clients enrolled in the NMMCP for the mental health and substance abuse benefits package will be reimbursed by the plan.

10-010.03D1: For payment of inpatient hospital psychiatric services, for the purpose of rate setting, the starting point shall be the tiered per diem amount effective on July 1 of state fiscal year (SFY) 2010. The starting point shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The tiered per diem amounts are adjusted annually and shall be effective each July 1.

10-010.03D2 Payment for Hospital Sponsored Psychiatric Residential Treatment Facilities (PRTFs): Payments for hospital sponsored PRTFs are made on a prospective per diem basis. The starting point for the rate was developed using standardized expense reports. Medicaid will not pay more than the facility's usual and customary daily charges billed for eligible clients. Pharmacy and physician services may be billed separately apart from the facility per diem. Public PRTFs will be cost-settled annually. Payment rates do not include costs of providing educational services. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The prospective payment amounts are adjusted annually and shall be effective each July 1.

10-010.03D3 Payment for Psychiatric Adult Inpatient Subacute Hospital Services: Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all inclusive per diem, with the exception of physician services. The starting point shall be the per diem amount effective on July 1 of state fiscal year (SFY) 2010. The starting point shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The per diem payment amounts are adjusted annually and shall be effective each July 1.

10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of –

1. The hospital-specific base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission but not for the day of discharge.

10-010.03E1 Calculation of Hospital-Specific Base Payment Amount: The hospital-specific base payment per diem is calculated as 100 percent of the median of the hospital-specific base year operating costs for the base year per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units.

10-010.03E2 Adjustment of Hospital-Specific Base Payment Amount: Each SFY, the hospital-specific base payment amount shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The hospital-specific base payment amounts are adjusted annually and shall be effective each July 1.

10-010.03E3 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem as described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

10-010.03F1 Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.03F, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for Medicaid. This requirement does not apply to a hospital:
   a. The inpatients of which are predominantly individuals under 18 years of age; or
   b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.
   c. For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. Only Nebraska hospitals which have a current enrollment with Nebraska Medicaid will be considered for eligibility as a Disproportionate Share Hospital.

10-010.03H1 Disproportionate Share Eligibility Calculation: To calculate eligibility, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a Disproportionate Share Hospital will be calculated using the following data:

1. To determine the Medicaid Inpatient Utilization Rate, the denominator will be the total days as reported on the Medicare Cost Report. The numerator will be the sum of each hospital's Medicaid days, which includes the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made. Only secondary payor days in the MMIS claims file data will be included.
2. To determine the Low-Income Utilization Rate, data from the Nebraska Accounting System will be used to calculate the Low-Income Utilization Rate for State-Owned Institutions for Mental Disease (IMDs). For all other hospitals, the hospital's certified report of total revenue, Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

10-010.03H2 Disproportionate Share Hospital (DSH) Upper Payment Limit and Uncompensated Care Calculation: The Disproportionate Share Hospital upper payment limit and the uncompensated care calculation is the sum of the Medicaid shortfall plus the cost of uninsured care.

1. The Department will calculate the Medicaid shortfall as follows:
   a. The Department will determine the costs of Medicaid fee-for-service and managed care inpatient services by:
      (1) Calculating a hospital's routine cost per day for each cost center (e.g., Adult, Pediatrics, etc.) from the CMS 2552 cost report by dividing the total costs by the total days; and
      (2) Multiplying the cost per day times the number of Medicaid allowable days provided during the same fiscal year as the filed cost report, and paid up to 150 days after the end of the fiscal year.
   b. The Department will determine costs of Medicaid fee-for-service and managed care outpatient services by:
      (1) Calculating a hospital's ancillary cost to charge ratio from the CMS 2552 cost report; and

(2) Multiplying the total Medicaid allowable charges times the ancillary cost to charge ratio.

c. The total Medicaid cost is the sum of the inpatient and outpatient costs for each hospital.

d. The Medicaid shortfall is determined by subtracting the total allowable Medicaid payments from the total Medicaid cost.

2. The Department will calculate the cost of uninsured care by using each hospital's charges for services provided to uninsured patients as filed and certified to the Department for the same fiscal year as the CMS cost report used in determining costs. The Department will convert each hospital's charges to cost for uninsured patients by multiplying the charges by the overall cost–to-charge ratio determined using hospital's CMS 2552 report for the same fiscal year used in determining cost.

3. The Medicaid upper payment limit and the uncompensated care amount is the sum of the Medicaid shortfall plus the cost of uninsured care.

10-010.03H3 Disproportionate Share Payments: Disproportionate share payments will be made annually for each federal fiscal year (FFY) following receipt of all required data by the Department. The total of all disproportionate share payments must not exceed the limits on disproportionate share hospital funding as established for this State by the Centers for Medicare and Medicaid Services (CMS) in accordance with the provisions of the Social Security Act, Title XIX, Section 1923. Payments determined for each federal fiscal year will be considered payment for that year, and not for the year from which proxy data used in the calculation was taken. To calculate payment, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination will be applied.

10-010.03H3a For FFY07 and succeeding years, the Department will make a disproportionate share hospital payment to hospitals that qualify for a payment under one of the following pool distribution methods.

10-010.03H3a(1) Basic Disproportionate Share Payment (Pool 1): Pool 1 consists of eligible hospitals in Peer Groups 2, 3, and 6 that are not eligible under Pool 6.

10-010.03H3a(1)(a) Total funding to Pool 1 will be $1,000,000. In FFY 2008 and following years, this amount will be increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment as follows:

1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the

Medicaid inpatient days of all hospitals which qualify for a payment in Pool 1.

2. Second, the ratio resulting from the division will be multiplied by the total funding for Pool 1 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 1, the additional funds will be redistributed prorata to eligible hospitals within Pool 1.

10-010.03H3a(2) Basic Disproportionate Share Payment (Pool 2): Pool 2 consists of eligible hospitals in Peer Groups 1, 2, and 3 that are also eligible under Pool 6.

10-010.03H3a(2)(a) Total funding to the Pool 2 will be $3,154,000 for FFY 2007, and $2,654,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment for Pool 2 as follows:

1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 2.
2. Second, the ratio resulting from the division will be multiplied by the total funding for Pool 2 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 2, the additional funds will be redistributed prorata to eligible hospitals within Pool 2.

10-010.03H3a(3) Disproportionate Share Payment for Hospitals that Primarily Serve Children (Pool 3): Pool 3 consists of the hospital that both primarily serves children age 20 and under and has the greatest number of Medicaid days.

10-010.03H3a(3)(a) Total funding for Pool 3 will be $3,138,000 for FFY 2007, and $3,638,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). A hospital eligible for payment under this pool will not be eligible for payment under any other pool. If payment to the hospital exceeds the disproportionate share hospital payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.

10-010.03H3a(4) Disproportionate Share Payment for State-Owned Institutions for Mental Disease (IMD) Hospitals and for Eligible Hospitals in Peer Group 4 (Pool 4): Pool 4 consists of state-owned institutions for mental disease hospitals and other eligible hospitals in Peer Group 4.

10-010.03H3a(4)a Total funding for Pool 4 will be $1,811,337 annually. The Department will calculate payments as follows:

1. Each eligible hospital must certify in writing to the Nebraska Medical Assistance Program its charges for uncompensated care for the hospital's fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospital's cost-to-charge ratio.
2. Payment to each hospital will be equal to the cost of its uncompensated care.
3. If the total of all disproportionate share payment amounts for Pool 4 exceeds the federally determined disproportionate share limit for Nebraska, the DSH payments will be reduced prorata.
4. A hospital eligible for payment under this pool will not be eligible for payment under any other pool.

10-010.03H3a(5) Non-Profit Acute Care Teaching Hospital Affiliated with a State-Owned University Medical College (Pool 5): Pool 5 consists of the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this pool may be eligible for payment under Pool 6.

10-010.03H3a(5)(a) Total funding to pool 5 will be $15,000,000. For FFY 08 and following years, the pool will be increased annually by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) . The Department will calculate the DSH payment to Pool 5 as an amount equal to the cost of its uncompensated care. If the payment to the hospital exceeds the disproportionate share payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced.

10-010.03H3a(6) Uncompensated Care Pool (Pool 6): Pool 6 consists of hospitals that provide services to low income persons covered by a county administered general assistance (GA) program; or hospitals that provide services to low-income persons covered by the state administered public behavioral health system.

10-010.03H3a(6)(a) Total funding to Pool 6 will be the remaining balance of the total (federal and state) DSH funding minus the funding for Pools 1, 2, 3, 4, and 5. The Department will calculate payments as follows:

1. DSH payments to a hospital under all other pools will be subtracted from the hospital's upper payment limit before allocating payments under Pool 6.
2. The costs for uncompensated care resulting from participation in the county administered general assistance (GA) program will be reported and funding transferred by the county; and costs for the state administered public behavioral health system will be reported by each hospital and funding transferred to the Medicaid agency. Reported costs will be subject to audit.
3. A ratio for each hospital will be determined based on the uncompensated cost amount transferred for each hospital to the total uncompensated cost transferred for all hospitals in Pool 6.
4. The ratio for each hospital will be multiplied by the available funding to the Pool.
5. The total computable payment will be commensurate with the transferred amount for uncompensated care resulting from participation in county administered general assistance (GA) program; or the state administered public behavioral health system as the state matching shares.
6. The annual payment amount will be dispersed in twelve monthly payments as transferred to the Medicaid agency.
7. If payment to the hospital exceeds the disproportionate share payment limit as established under section 1923(f) of the Social Security Act, the payment will be reduced to the payment limit.
8. If payments to hospitals under this pool exceed the total funding to the pool, the payments will be reduced prorata.

10-010.03H3b Limitations on Disproportionate Share Payments: The Department will apply the following limitations to disproportionate share payments:

1. No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923(g)(1)(A) of the Social Security Act.
2. Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923(f) of the Social Security Act.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services using the same methods described in this regulation for in-state hospitals, except that out-of-state hospitals do not receive direct medical education cost payments or indirect medical education cost payments. Payments for services are determined by assigning out-of-state hospitals to the appropriate peer group. The peer groups are:

1. Metro Acute Care Hospitals: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare;
2. Rural Acute Care Hospitals: All other acute care hospitals;
3. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.
4. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.

For peer groups 1 and 3, operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the appropriate peer group capital per diem rate. The cost-to-charge ratios for out-of-state hospitals that meet the criteria for inclusion in the calculation of DRG at section 10-010.03B1a of this regulation are determined using the same method described for in-state hospitals in Section 10-010.03B of this regulation. The cost-to-charge ratios for all other out-of-state hospitals are the peer group average of in-state hospitals.

Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

Tiered rates as described in 471 NAC 10-010.03D1, will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payments for rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Payments for rehabilitation hospitals are based on average of the in-state hospital specific per diem rates for the appropriate type of service. Capital-related cost payments are made based on the in-state peer group capital per diem rate.

10-010.03J1 Exception: The Administrator of the Medicaid Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in 471 NAC 10-010.03J only when the Medical Director of the Department has determined that -

1. The client requires specialized services that are not available in Nebraska; and
2. No other source of the specialized services can be found to provide the services at the rate established in 471 NAC 10-010.03J.

10-010.03K Out-of-Plan Services: When enrollees in the Nebraska Health Connection are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are authorized, but are not required, to pay providers of hospital inpatient services who care for individuals enrolled in the Nebraska Health Connection at rates the Department would otherwise reimburse providers under 471 NAC 10-010.03ff.

10-010.03L Free-Standing Psychiatric Hospitals: When a free-standing psychiatric hospital (in Nebraska or out of state) does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service shall bill NMAP for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. The hospital's rate is calculated according to 471 NAC 10-010.03D, and/or 10-010.03J. This is an exception to regulations governing the elimination of combined billing in 471 NAC 10-003.05C through 10-003.05F6e.

10-010.03M Rate-Setting Following a Change in Ownership: The rate-setting process for facilities with a change in ownership will be the same as the rate-setting process used prior to the change in ownership as described in these regulations.

10-010.03N Rate-Setting Following a Hospital Merger: Hospitals that have combined into a single entity shall be assigned a single combined weighted average for each of the following: direct medical education amount, if applicable, indirect medical education amount, if applicable, cost-to-charge ratio, outpatient percentage, capital amount, and any other applicable rates or add-ons. The weights shall equal each hospital’s base year Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the current fiscal year rates which were calculated for each hospital.

10-010.03O Rate-Setting for a New Operational Facility: The Department shall establish a prospective per discharge rate for a new operational facility for Peer Groups 1-5. The rate will be the average peer group rate for the respective peer group for the new facility. For critical access hospitals, the rate will be determined individually for each hospital based on reasonable cost. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as a Regional Rural Referral Center;
3. Rural Acute Care Hospitals: All other acute care hospitals with 30 or more base year Medicaid discharges;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the Nebraska Department of Health and Human Services Regulation and Licensure and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the Nebraska Department of Health and Human Services Regulation and Licensure and distinct parts as defined in these regulations.
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

10-010.03P Depreciation: The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

10-010.03Q Recapture of Depreciation: A hospital which is sold for a profit and has received NMAP payments for depreciation shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department; or
2. The product of -
   a. The ratio of Medicaid allowed inpatient days to total inpatient days; and
   b. The amount of gain on the sale as determined by the Medicare intermediary.

$$\frac{\text{\# of Medicaid Inpatient Days}}{\text{Total \# of Inpatient Days}} \times \text{Gain on Sale in \$} = \text{Recapture Amount}$$

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

10-010.03R Adjustment to Rate: Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current and/or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital shall refund the overpayment amount as determined by the Department to the Department. If the rate adjustment results in increasing a hospital's rate, the Department shall reimburse the underpayment amount as determined by the Department to the hospital.

10-010.03S Lower Levels of Care: When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year.

When a Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process (PASP), the Department may pay for the PASP days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. The hospital shall request prior authorization from the Medicaid Division before the PASP days are provided. The Medicaid Division will send the authorization to the hospital. The hospital shall bill the appropriate bill type and revenue code and enter the prior authorization document number from Form MC-9 on Form CMS-1450 or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278). The claim for the PASP days must be separate from the claim for the inpatient days paid at the acute rate. The PASP days will be disallowed as acute care days and NMAP will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the PASP day. PASP days will not be considered in computing the hospital's prospective rate.

10-010.03T Access to Records: Hospitals shall make all records relating to the care of Medicaid patients and any and all other cost information available to the Department, its designated representatives or agents, and/or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

Hospitals shall allow authorized representatives of the Department of Health and Human Services Finance and Support, the federal Department of Health and Human Services, and state and federal fraud and abuse units to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department. The hospital shall allow the authorized representatives access for the purpose of audit and review at any reasonable time during normal working hours upon written notice by the Department at least one working day before the review and audit.

10-010.03U Audits: The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

10-010.03V Provider Appeals: A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date according to the procedures in 471 NAC 2-003 ff. A hospital may also request an adjustment to its rate (see 471 NAC 10-010.03W).

10-010.03W Request for Rate Adjustments: Hospitals may submit a request to the Department for an adjustment to their rates for the following:

1. An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate if the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate.
2. Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate for extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. extraordinary circumstances are limited to -

    a. Changes in routine and ancillary costs, which are limited to -
        (1) Intern and resident related medical education costs; and
        (2) Establishment of a subspecialty care unit;
    b. Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.

3. Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:
    a. One-time occurrence;
    b. Less than twelve-month duration;
    c. Could not have been reasonably predicted;
    d. Not of an insurable nature;
    e. Not covered by federal or state disaster relief;
    f. Not a result of malpractice or negligence.

In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital.

If an adjustment is granted, the peer group rates will not be changed.

In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following:

1. Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control.
2. Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.
3. The rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.

Requests for rate adjustments must be submitted in writing to the Administrator, Medicaid Division, Nebraska Department of Health and Human Services Finance and Support. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, the Department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Department's receipt of the request. Regardless of the Department's decision, the provider will be afforded the opportunity for a conference if requested for a full explanation of the factors involved and the Department's decision. Following review of the matter, the Administrator shall notify the facility of the action to be taken by the Department within 30 days of receipt of the request for review or the date of the conference, except in circumstances where additional information is requested or additional investigation or analysis is determined to be necessary by the Department.

If rate relief is granted as a result of a rate adjustment request, the relief applies only to the rate year for which the request is submitted (except for corrections of errors in rate determination). If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.

Under no circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology.

10-010.03X Administrative Finality: See 471 NAC 3-002.10.

10-010.04 (Reserved)

10-010.05 (Reserved)

10-010.06 Payment for Outpatient Hospital and Emergency Room Services: The starting point for the outpatient hospital and emergency services rate shall be a rate which is the product of:

1. Seventy-five (75) percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The effective date of the cost-to-charges ratio is the first day of the month following the Department's receipt of the cost report. Each state fiscal year, the outpatient hospital and emergency services rate shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. Outpatient hospital and emergency services rates shall be effective each July 1.

Providers shall bill outpatient hospital and emergency room services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services at the fee schedule determined by CMS. See 471-000-520 and 471 NAC 10-003.05F5b.

10-010.06A Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Payment for outpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. The Department will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made at the reasonable cost of providing these services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, the Department will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

10-003.06A1 Adjustment Based on Legislative Appropriations: The starting point for the payment amounts, as determined in section 10-010.06A, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature.

10-010.06B Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to 471 NAC 26-005.

10-010.06C Payment for Outpatient Mental Health and Substance Abuse Services in a Hospital: Providers shall use HCPCS procedure codes when submitting claims to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

1. Level 1: The codes contained in the most recently published edition of the American Medical Association's Current Procedural Terminology (CPT); and
2. Level 2: Federally defined alpha-numeric HCPCS codes.

The Nebraska Medical Assistance Program (Medicaid) pays for covered outpatient mental health services, except for laboratory services, at the lower of –

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as –
   a. The unit value multiplied by the conversion factor;
   b. The maximum allowable dollar amount; or
   c. The reasonable charge for the procedure as determined by Medicaid (indicated as "BR" – by report or "RNE" – rate not established in the fee schedule).

HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518 and 471-000-532).

10-010.06C1 Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to –

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally recognized systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when Medicaid determines that the current allowable amount is –
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

See 471 NAC 20-002.11 and 13 and 471 NAC 32-002.11 and 15.

10-010.06D Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for an emergency medical condition, (see emergency medical condition in 471 NAC 10-001.02);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by his or her physician for treatment in an emergency room.

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency medical condition and bill accordingly.

When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of what would otherwise be allowed. All other Medicaid allowable charges incurred in this type of visit will be paid according to 471 NAC 10-010.06.

10-010.06E Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as state fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

10-010.06F Payment to a New Hospital for Outpatient Services: See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (a new operational facility) will be made at the statewide average ratio of cost to charges for Nebraska hospitals as determined by the Department according to 471 NAC 10-010.06. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department according to 471 NAC 10-010.06.

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 et seq.)

10-010.06G Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges for all Nebraska hospitals. See 471 NAC 10-010.06.

10-010.07 (Reserved)

10-010.08 Administrative Finality: See 471 NAC 3-002.10.

10-010.09 Limitations on Payment for Hospital Services

10-010.09A Place of Service: The Medical Services Division may review and reduce or deny payment for covered outpatient or emergency room drugs, supplies, or services which are readily obtainable from another provider (i.e., pharmacy, physician's office) at the time provided to the amount payable at the least expensive appropriate place of service.

10-010.09B Items Not Utilized in the Facility: Drugs, medical supplies, and services not utilized in the hospital must be obtained from and billed by the appropriate provider. Exception: Take-home supplies.

Also see 471 NAC 10-003.02C regarding take-home drugs and 471 NAC 10-003.03C regarding take-home supplies.

NMAP does not cover drugs, supplies, and services not utilized in the hospital for nursing home residents when billed by the hospital because payment is included in the nursing home per diem.

10-010.09C Outpatient/Emergency Services on the Same Day as Inpatient Services: When a client receives outpatient/emergency room hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the outpatient/emergency room hospital services are treated as inpatient services for billing purposes.

10-010.09D Billed Charges: Inpatient hospital services are paid on a prospective rate basis, regardless of billed charges.

10-010.10 Medically Unnecessary Inpatient Hospitalization: See 471 NAC 3-001.10.

10-010.11 NMAP's Surveillance and Utilization Review of Hospital Services: The Nebraska Department of Health and Human Services Finance and Support or its designee reviews hospital inpatient services for medical necessity, appropriateness of service, and level of care. The review may also include validation of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, continued hospitalization, discharge, and transfer; and appropriateness of prospective payment outlier cases.

10-010.11A Review Activities for Hospital Inpatient Services Reimbursed on a Prospective Per Discharge Basis: All hospital inpatient services reimbursed on a prospective per discharge basis (by DRG) are subject to random retrospective review by the Department or its designee. Admissions within three calendar days of a hospital outpatient service may be included in the sample. In addition to the random sample, focused reviews of inpatient stays for heart or liver transplant(s), NICU stays provided in a subspecialty care facility and/or cost outliers may be done by the Department or its designee.

Review for all selected cases will include: DRG validation, including validation of diagnostic and procedural information and ICD-10-CM coding; medical necessity for inpatient admission and procedure(s); stability at discharge; and quality of care. Payment for inpatient services can be denied if either admissions or discharges are performed without medical justification as determined by the Department or its designee. Payment can be reduced if coding inaccuracies are identified by the Department or its designee. Any cost outlier which is not determined to be medically necessary for hospital inpatient care by the Department or its designee may qualify for payment as a lower level of care payment.

10-010.11B Review Activities for Hospital Inpatient Services Reimbursed on a Prospective Per Diem Basis: Hospital inpatient care must be reasonable, medically necessary, and appropriate for the class of care being billed. All hospital inpatient admissions (see exceptions below) must be certified by the Department or its designee prior to payment. Review will include medical necessity, appropriateness of service, and level of care. Payment for services will be denied if the Department or its designee determines the service was not medically necessary. The Department or its designee will conduct these activities through pre-admission, concurrent, and retrospective reviews.

If the class of care is not appropriate, the claim may be reduced to the appropriate level of care according to 471 NAC 10-010.03S (i.e., skilled, bassinet) or denied.

10-010.11C Surveillance and Utilization Review of Hospital Outpatient Services: Claims for payment for hospital outpatient services are subject to review by the Department or its designee. Hospital outpatient care must be reasonable and medically necessary, and must be provided in the most appropriate place of service.

10-010.11D Billing the Client: When an individual is admitted to a hospital as a non-Medicaid patient and is later determined to be eligible for NMAP, the hospital shall not bill the client for services that are covered by NMAP. If the services are covered by NMAP but have been denied based on medical necessity, the provider shall not bill the client. The hospital may bill the client for those services that are specifically not covered by NMAP, such as cosmetic surgery.

10-011 Billing Requirements: Providers of hospital services shall submit claims to the Department on Form CMS-1450 see 471-000-51. Also see 471 NAC 3-003, Medicare/Medicaid Claims. Instructions for completing Form CMS-1450 have been published in the Nebraska Uniform Billing Data Element Specifications manual published by the Nebraska Uniform Billing Committee. Providers may purchase copies from the Nebraska Association of Hospitals and Health Systems. Providers using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) shall refer to the Claim Submission Table at 471-000-49.

10-011.01 Medicare Coverage: For a Medicare/Medicaid client, the provider shall bill Medicare for appropriate benefits before submitting a claim to Medicaid. (Exception: Medicare non-covered services covered by Medicaid).

10-011.02 Medicare Part B: If the Medicare/Medicaid client has exhausted his/her Medicare Part A benefits, the hospital shall bill these services or items to Medicare Part B if the client is covered by Part B before billing the Department. The hospital shall enter the amount approved by Medicare as a "prior payment" on Form CMS-1450 see 471-000-51 on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

10-011.03 Documentation: The Department requires that documentation when required, be submitted with each claim for hospital services. Documentation must be complete and legible.

Note: All Nebraska Medicaid Program clients sign a release of information statement when they apply for Medicaid. If the hospital requires another release, the hospital must obtain that release, based on the provider agreement with the Department.

10-011.04 Hospital-Acquired Conditions (HAC): Effective for inpatient and inpatient crossover claims with a 'From' date of service on or after the effective date of this regulation, hospitals are required to report whether each diagnosis on a Medicaid claim was present at the time of patient admission, or present on admission (POA). Claims submitted without the required POA indicators will be denied.

For claims containing diagnoses that are identified by Medicare as Hospital-Acquired Conditions, other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients and for which the condition was not POA, these diagnoses will not be used for AP-DRG grouping. The claim will be paid as though any diagnoses included in the list of HACs were not present on the claim. The Department does not make additional payments for services on inpatient hospital claims that are attributable to HACs and are coded with POA indicator codes "N" or "U". Specifically, for hospitals paid under the:

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

2. Cost to Charges (CCR) payment method, the Department does not pay for charges attributable to the HAC.

3. Per Diem payment method, the Department will limit provider payment reductions to the extent that the identified PPC would otherwise result in an increase in payment, or if Medicaid can reasonably isolate for nonpayment the portion of the payment directly related to the PPC.

The Department denies payment for any HAC that results in death or serious disability.

10-011.04A Other Provider Preventable Condition (OPPC): Effective for inpatient, inpatient crossover, outpatient and outpatient hospital claims with a 'From' date of service on or after the effective date of this regulation, payment will be denied for the following Other Provider Preventable Conditions:

1. Wrong surgical or other invasive procedure performed on a patient;
2. Wrong surgical or other invasive procedure performed on the wrong body part;
3. Wrong surgical or other invasive procedure performed on the wrong patient.

10-012 Hospital Utilization Review (UR): Each hospital must have in effect a utilization review plan that provides for review of services provided by the hospital and by members of the medical staff to Medicaid patients.

10-012.01 Composition of the Utilization Review Committee: A UR committee consisting of two or more practitioners must carry out the UR function. At least two members of the committee must be doctors of medicine or osteopathy. The other members may be -

1. A doctor of medicine or osteopathy;
2. A doctor of dental surgery or dental medicine;
3. A doctor of podiatric medicine;
4. A doctor of optometry; or
5. A chiropractor.

10-012.01A UR Committee: The UR committee must be -

1. A staff committee of the institution; or
2. A group outside the institution established by the local medical society and some or all of the hospitals in the locality or established in a manner approved by CMS.

If, because of the small size of the institution, it is impossible to have a properly functioning staff committee, the UR committee must be established under item 2 above.

The committee's or group's reviews may not be conducted by any individual who has a direct financial interest in that hospital or was professionally involved in the care of the patient whose case is being reviewed.

10-012.02 Scope and Frequency of Reviews: The UR plan must provide for review of Medicaid patients with respect to the medical necessity of -

1. Admissions to the hospital;
2. The duration of stays; and
3. Professional services provided, including drugs. Review of admissions may be performed before, at, or after hospital admission. Except for extended stay reviews under 471 NAC 10-012.04, reviews may be conducted on a sample basis.

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10-012.03 Determinations Regarding Denial of Medical Necessity of Admissions or Continued Stays: The determination that an admission or continued stay is not medically necessary -

1. May be made by one member of the UR committee if the practitioner(s) responsible for the patient's care concur with the determination or fail to present his/her view when given the opportunity; or
2. In all other cases, must be made by at least two members of the UR committee.

Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner(s) responsible for the care of the patient, and afford the practitioner(s) the opportunity to present his/her views. If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given no later than two days after the determination, to the hospital, the patient, and the practitioner(s) responsible for the care of the patient.

See 471 NAC 10-010.11 ff. regarding medical review activities.

10-012.03A Billing the Client: It is not a violation of NMAP's policy for the hospital to bill the client for services provided after the date the client receives notification if the following criteria are met:

1. The hospital's utilization review committee has determined that an admission or an extended stay is/was not medically necessary;
2. The hospital has met the client notification requirements in 471 NAC 10-012.03; and
3. The NMAP (Medicaid) client chooses to remain in the hospital or be admitted to the hospital.

10-012.04 Extended Stay Review: The UR committee must make a periodic review as specified in the UR plan of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling or the periodic reviews may be the same for all cases or different for different classes of cases.

10-012.05 Review of Professional Services: The UR committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

10-012.06 Recertification of Continued Stay: Recertifications must be made at least every 60 days after initial certification. Exception: Psychiatric inpatient care must be certified every 30 days under 471 NAC 20-001.07.

10-013 Medical Records: The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

10-013.01 Organization and Staffing: The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written,, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentification and protects the security of all record entries.
Medical records must be retained in their original or legally reproduced form for a period of five years.

The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

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

10-013.02 Content of Record: The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

The author of each entry must be identified and must authenticate his/her entry.

Authentication may include signatures, written initials, or computer entry.

All records must document the following, as appropriate:

1. Evidence of a physical examination, including a health history, performed no more than seven days before admissions or within 48 hours after admission;
2. Admitting diagnosis;

3. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient;
4. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;
5. Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by federal or state law if applicable, to require written patient consent;
6. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs, and other information necessary to monitor the patient's condition;
7. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care; and
8. Final diagnosis with completion of medical records within 30 days following discharge.

10-014 Swing Beds: NMAP covers only skilled nursing care (client requires 24-hour professional nursing care) for swing beds. Also see 471 NAC 12-008.08 ff. Swing bed services are services that meet the requirements of 42 CFR 483, Subpart B. Nursing or rehabilitation services which must be provided by or under the direct supervision of professional or technical personnel and require skilled knowledge, judgment, observation, and assessment may include, but are not limited to, the following:

1. Orally administered medications which require changes in dosage due to undesirable side effects or reactions, e.g., anticoagulants, Quinidine, etc. These must be administered to the patient by licensed nurses;
2. Frequent intravenous or intramuscular injections, except self-administered types such as insulin for a well-regulated diabetic;
3. Narcotics and controlled substances used on a p.r.n. (as circumstances may require) basis. Care relative to these substances must be documented in nurses' notes and physicians' orders with progress notes which contain observations made of the physical findings, new developments in the disease cause, how the prescribed treatment was implemented, and the resultant effects of the treatment;
4. Supplementation of physician care when -
   a. Uncontrolled or unstable medical conditions exist; and/or
   b. Observations of and instructions to the patient are needed relative to critical complications and evaluation of progress;
5. Initial phases of a medical regimen involving the administration of medical gases as directed by physicians' orders;
6. Physician-ordered restorative procedures which, because of the type of procedure or the patient's condition, must be performed by or under the direct supervision of the appropriately qualified therapist as defined in 42 CFR 483.45 (Note: Maintenance therapy is not skilled nursing care);
7. Colostomy or ileostomy care during the post-operative period until routine care is established;

8. Frequent catheterization or indwelling catheter care: urinary, bile ducts, chest, etc., or in combination with other skilled services;
9. Application of aseptic dressings and treatments (i.e., wound, tracheostomy care);
10. Nasopharyngeal aspiration and throat suctioning;
11. Levine tube and gastrostomy feedings; and
12. Decubitus ulcers - Stage III or IV.

The requirements of PASARRP and resident assessment (MDS) do not apply to swing beds.

10-014.01 Standards for Participation: To participate in Medicaid as a provider of swing-bed services, the hospital must be certified as a Medicare swing-bed facility by the Nebraska Department of Health and Human Services, Division of Public Health.

10-014.02 Provider Agreement: To be approved by the Department as a swing-bed provider, the hospital shall complete and sign Form MC-20. The agreement must be submitted to and approved by the Department. If the hospital has an approved agreement with the Department, it is not necessary to complete another Form MC-20 to provide swing-bed services.

10-014.03 Prior Authorization: To obtain prior authorization for payment for a client admitted to a swing bed, facility staff shall within 15 days of the date of admission to the swing bed -

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C or use the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);
2. Submit a copy of Form DM-5 or physician's history and physical;
3. Complete Form DM-5LTC, "Long Term Care Evaluation;" and
4. Submit all the information to the local office.

10-014.04 Payment: Medicaid pays for swing-bed services at the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

To bill Medicaid for swing-bed services, the hospital shall use Form MC-4, "Long Term Care Facility Turnaround Billing Document" (see 471-000-82) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). If Medicare is covering the swing-bed services, the facility shall bill according to Medicare instructions.

When the client no longer requires a skilled level of care, Medicaid may authorize payment for up to five working days of care, when necessity to facilitate transfer to the appropriate level of care.

10-014.05 Ancillary Services: If the hospital bills for swing bed services on Form MC-4, the hospital shall bill as follows for ancillary services for swing-bed patients who are eligible for Medicaid only. If Medicare is covering the swing-bed services, the facility shall not bill NMAP for ancillary services.

Laboratory, radiology, respiratory therapy, physical therapy, occupational therapy, and speech pathology and audiology services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) as outpatient services. These payment must be reported on the Medicare cost report as outpatient revenues.

Drugs must be billed via NE-POP by a licensed pharmacy. "Drug room" services cannot be billed separately.

Medical supplies are included in the rate for swing-bed services. Durable medical equipment and oxygen that are not considered part of the swing-bed service must be billed by the supplier. See 471 NAC 12-008.05, 12-008.06, 12-011.04B, and 12-011.04C regarding what is considered part of the per diem and what must be billed by the supplier.