TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 10 HOSPITAL SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

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

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

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

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

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

002.06 COMORBIDITY. The simultaneous presence of two chronic diseases, or conditions, in a patient.

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

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

002.09 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.

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

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

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

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

002.14 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.

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

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

002.16 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.

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

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

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

002.19 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) or pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

002.20 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.

002.21 HOSPITAL INPATIENT SERVICES. Services that:

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

002.22 HOSPITAL MERGERS. Hospitals that have combined into a single entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

002.23 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. 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.

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

002.25 HOSPITAL-AFFILIATED AMBULATORY SURGICAL CENTER (HAASC). An ambulatory surgical center operated by a hospital. A hospital-affiliated ambulatory surgical center (HAASC) may be covered under Medicare, and therefore under Nebraska Medicaid,

as an ambulatory surgical center (ASC) or a hospital-affiliated ambulatory surgical center (HAASC).

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

002.27 HOSPITAL-SPECIFIC BASE YEAR OPERATING COST. Hospital-specific operating allowable cost associated with treating Nebraska 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.

002.28 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 diagnosis-related group cost-to-charge ratio (CCR) payments are derived from the outlier cost-to-charge ratios (CCR) in the Medicare inpatient prospective payment system.

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

002.30 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 cost payments.

002.31 INFANT OR INFANCY. The time period from an individual’s birth through completion of one year of age.

002.32 INPATIENT. A patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who:

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

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

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

002.33(A) PART OF DAY. Except for the day of admission, a part of a day, including the day of discharge, death, or a day on which a patient 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.

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

002.33(C) MEDICARE METHODOLOGY. The Department utilizes the current Medicare methodology in accounting for the inpatient accommodations on the Nebraska Medicare cost report.

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

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

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

002.35 MEDICAID ALLOWABLE INPATIENT CHARGES. Total claim submitted charges less claim non-allowable amount.

002.36 MEDICAID ALLOWABLE INPATIENT DAYS. The total number of covered Medicaid inpatient days.

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

period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Nebraska Medicaid rate period.

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

002.39 MEDICAL NECESSITY. Health care services and supplies which are medically appropriate and:

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

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

002.41 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:

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

002.42 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 their licensure. This includes dressings, colostomy supplies, catheters, and other similar items.

002.43 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.

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

002.45 NEW OPERATIONAL FACILITY. A facility providing inpatient hospital care which meets one of the following criteria:

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

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

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

002.46 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.

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

002.48 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.

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

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

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

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

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

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

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

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

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

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

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

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

002.61 SEVERE OBESITY. Body Mass Index greater than 35.

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

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

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

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

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

002.64 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.

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

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

002.67 WARD. Either:

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

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

003. PROVIDER REQUIREMENTS.

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

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

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

(ii) Be licensed as a hospital by the Department or the officially designated authority for state standard-setting in the state where the hospital is located;

(iii) Have licensed and certified hospital beds; and

(iv) Meet the requirements for participation in Medicare and Medicaid.

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

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

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

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

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

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

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

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

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

003.02(E)(i) PROVIDER RE-APPROVAL. Each hospital approved by the Department to provide ambulatory room and board services must 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.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

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

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

004.01(B) PRIOR AUTHORIZATION. The Department requires that physicians request prior authorization from the Department before providing:

(1) Medical transplants;
(2) Abortions;
(3) Cosmetic and reconstructive surgery;
(4) Bariatric surgery for obesity;
(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;
(10) Sleep study for a child under the age of six years old; and
(11) Ventricular Assist Device.

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

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

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

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

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

(a) Physician(s) submitting or contributing to the request;
(b) Caseworker; and
(c) Medical Review Organization when appropriate.

004.01(B)(ii) VERBAL AUTHORIZATION PROCEDURES. The Department may issue a verbal authorization when circumstances are of an emergency nature, or urgent to the extent that a delay would place the client at risk of not receiving medical

care. When a verbal authorization is granted, a written request or electronic request using the standard electronic Health Care Services Review – Request for Review and Response transaction must be submitted within 14 days of the verbal authorization. A written or electronic response from the Department will be issued upon completion of the review.

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

004.02 SPECIFIC REQUIREMENTS.

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

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

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

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

004.02(B) PRIOR AUTHORIZATION FOR TRANSPLANT SERVICES. The Department requires prior authorization of all transplant services. Physicians must request prior authorization before performing any transplant service or related donor service.

004.02(B)(i) Prior authorization requests must include at a minimum:

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

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

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

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

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

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

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

(c) A written statement by the physician:

(i) Recommending the transplant;

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

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

004.02(C) PRIOR AUTHORIZATION FOR GASTRIC BYPASS SURGERY. Prior authorization request must include, but is not limited to, documentation of:

(i) Medical diagnoses;

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

(1) Diabetes Mellitus (include recent lab results and current medications);

(2) Hypertension (include current medications, including antihypertensive and blood pressure readings);

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

(4) Obstructive sleep apnea (include sleep study results and treatment);

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

(6) Osteoarthritis (include information about the client’s ability to ambulate, assistive devices used and any medications being used to manage symptoms);

(7) Pseudo tumor cerebri (include diagnostic reports/imaging); or

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

(iii) Dietary consultation, including documentation showing completion of a supervised diet program for six months or more, and a determination that the patient is motivated to comply with dietary changes;

(iv) Psychiatry or psychology consultation that includes:

(1) Evaluation to determine readiness for surgery and lifestyle change; and

(2) No behavior health disorder by history and physical exam:

(a) Exam includes no severe psychosis or personal disorder; and

(b) Mood or anxiety disorder excluded and treatment (if treated, include treatment medications or modalities).

(v) Drug or alcohol screen:

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

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

004.03 COVERED INPATIENT SERVICES.

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

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

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

004.03(D) SERVICES OF INTERNS AND RESIDENTS-IN-TRAINING. The Department 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.

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

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

004.03(E) OUTPATIENT/EMERGENCY SERVICES. When a client receives hospital outpatient or emergency room services and is thereafter admitted as an inpatient of the same hospital before midnight of the same day, the hospital outpatient or emergency room services are covered by the Department as inpatient services. Hospital outpatient services furnished in the outpatient or 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.

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

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

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

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

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

004.04 DRUGS.

004.04(A) INPATIENT DRUGS. The Department 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.

004.04(B) HOSPITAL OUTPATIENT OR EMERGENCY ROOM DRUGS. The Department covers drugs utilized in the actual treatment as part of the outpatient or emergency room service. The hospital must 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 National Drug Code (NDC). Include the correct National Drug Code (NDC) information on all claims, including Medicare and other third party claims.

004.05 MEDICAL SUPPLIES AND EQUIPMENT.

004.05(A) INPATIENT SUPPLIES AND EQUIPMENT. The Department covers 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.

004.05(B) HOSPITAL OUTPATIENT AND EMERGENCY ROOM SUPPLIES AND EQUIPMENT. The Department 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.

004.05(C) TAKE-HOME SUPPLIES AND EQUIPMENT. The Department covers the following supplies and equipment:

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

004.05(C)(i) INFANT APNEA MONITORS. The Department 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 or caregiver training must occur before placement of infant apnea monitor. Payment for hospital apnea monitoring services provided to an inpatient is included in the hospital payment for inpatient services.

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

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

004.06 LABORATORY AND PATHOLOGY.

004.06(A) PROFESSIONAL COMPONENT. The Department covers as a physician's service the professional component of laboratory services provided by a physician to an individual patient in accordance with the provisions of 471 NAC 18. The professional component must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

004.06(B) CLINICAL LAB SERVICES. Clinical laboratory services are considered technical components and must be billed as such. The Department covers the technical component of clinical laboratory services provided to hospital inpatients, outpatients, and non-patients performed by non-physicians manually or using automated laboratory equipment. 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 Centers for Medicare and Medicaid Services. Outpatient clinical laboratory services must be itemized on the appropriate claim form or electronic format using the appropriate healthcare common procedure coding system procedure codes.

(3) Non-Patient Services: Payment is made at the fee schedule determined by Centers for Medicare and Medicaid Services.

004.06(B)(i) LEASED DEPARTMENTS. Leased department status has no bearing on billing or payment for clinical lab services. The hospital must claim all clinical lab services, whether performed in a leased or non-leased department. Payment for the total service (professional and technical component) is made to the hospital. The Department does not make separate payment for the professional component for clinical lab services.

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

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

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

004.06(C)(ii) BILLING AND PAYMENT FOR HOSPITAL OUTPATIENT ANATOMICAL PATHOLOGY SERVICES. The hospital must bill the technical component of outpatient anatomical pathology services in a summary bill format using the appropriate revenue code on the appropriate claim form or electronic format. The pathologist must claim the professional component on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) using the appropriate healthcare common procedure system procedure code and a "26" modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

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

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

004.06(C)(iv) LEASED DEPARTMENTS. If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist must claim the total service (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.

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

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

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

004.07(B) 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; and
(2) Hospital services.

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

004.07(B)(ii) The technical component of outpatient and non-patient 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; including, but not limited to stat fees, specimen handling, call back, room charges, etc.

004.07(D) NON-PHYSICIAN SERVICES AND ITEMS. All non-physician services, drugs, medical supplies, and items, provided to hospital inpatients or outpatients must be provided directly by the hospital or under arrangements. If the services or items are provided under arrangements, the hospital is responsible for payment to the non-physician provider or supplier. The Department prohibits the "unbundling" of costs by hospitals for non-physician services or supplies provided to hospital patients, including ancillary services provided by another hospital.

004.08 RADIOLOGY. The Department covers medically necessary radiological services provided to inpatients and outpatients. The Department covers only those services which are directly related to the patient's diagnosis and the provider must indicate the diagnosis which reflects the condition for which the service is performed on the claim from, and if necessary, include a notation on the claim which documents the need. A radiological laboratory is not considered an independent laboratory under Medicaid. 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.

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

004.08(B) TECHNICAL COMPONENT. The Department covers 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.

004.08(C) COMPUTERIZED TOMOGRAPHY (CT) SCANS. The Department covers diagnostic examinations of the head and of certain other parts of the body performed by computerized tomography (CT) scanners when:
(i) Medical and scientific literature and opinion support the use of a scan for the condition;
(ii) The scan is reasonable and necessary for the individual patient; and

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

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

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

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

004.08(E) PORTABLE X-RAY SERVICES. The Department 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 must be met.

004.08(E)(i) COVERED PORTABLE X-RAY SERVICES. The Department 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; and

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

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

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

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

004.08(E)(iv)(1) NEBRASKA PORTABLE X-RAY PROVIDER. The provider must submit Form CMS-1539: Medicare/Medicaid Certification and Transmittal.

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

004.08(E)(v) 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.

004.08(E)(v)(1) When the services of a provider of portable x-ray services no longer meet the conditions of coverage, physicians responsible for supervising the portable x-ray services and having an interest in the x-ray provider's certification status must be notified. The notification action regarding suppliers of portable x-ray equipment is the same as required for decertification of independent laboratories, and the same procedures are followed.

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

004.08(G) BILLING AND PAYMENT FOR RADIOLOGY SERVICES.

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

004.08(G)(ii) BILLING AND PAYMENT FOR HOSPITAL OUTPATIENT RADIOLOGY SERVICES. The hospital must claim the technical component of outpatient radiology services on the appropriate claim form or electronic format. Payment is made according to 471 NAC 10. 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 Healthcare Common Procedure Coding System procedure code with a "26" modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

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

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

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

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

004.09(A)(i) 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. 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.

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

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

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

004.10(A) BILLING FOR HOSPITAL-BASED AMBULANCE SERVICES. Hospital-based ambulance services provided to an inpatient or an outpatient must be claimed on the appropriate claim format or electronic format as a hospital outpatient service by the

hospital-based ambulance provider. Hospital-based ambulance services are reimbursed as a hospital outpatient service. Hospital-based ambulance costs are not included in the calculations for hospital inpatient rates.

004.10(B) GROUND AMBULANCE SERVICES.

004.10(B)(i) BASIC LIFE SUPPORT (BLS) AMBULANCE. A basic life support (BLS) ambulance provides transportation plus the equipment and staff needed for basic services such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, cardio-pulmonary resuscitation (CPR), defibrillation, etc.

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

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

004.10(C) MILEAGE. Loaded mileage- 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.

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

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

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

004.10(F) AIR AMBULANCE. The Department covers 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.

004.10(F)(i) When billing the Department, the provider must 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.

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

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

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

004.10(G)(i)(1) 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.

004.10(G)(ii) 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 or practitioner that most appropriately meets the needs of the client, including:

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

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

(1) The 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 intermediate care facilities for individuals with developmental disabilities (ICF/DD).

004.10(G)(iv) ROUND TRIP TRANSPORTS FOR HOSPITAL INPATIENTS. Ambulance services provided to a client receiving hospital inpatient services, where the client is transported to another facility for services 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.

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

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

004.10(G)(vi) TRANSPORT OF MORE THAN ONE 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 the Department.

004.10(G)(vii) 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.

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

004.11 PRE-ADMISSION TESTING. The Department covers pre-admission testing and diagnostic services rendered up to three days before the day of admission, as an ancillary.

004.11(A) The Department 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.

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

(A) The test is specifically ordered by the admitting 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 their patients);

(B) The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and
(C) The test does not unnecessarily duplicate:
(i) The same test performed on an outpatient basis before admission; or,
(ii) The same test performed in connection with a separate, but recent, hospital admission.

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

004.13(A) COVERED SERVICES – PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES. The Department covers physical therapy, occupational therapy, speech pathology, and audiology services in accordance with the criteria outlined in 471 NAC 17, 471 NAC 14, and 471 NAC 23 respectively.

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

004.14 ANESTHESIOLOGY.

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

004.14(A)(i) MEDICAL DIRECTION OF FOUR OR FEWER CONCURRENT PROCEDURES. The Department covers 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), in accordance with 471 NAC 10. The professional component of personal services up to and including induction is covered as a physician's service and must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

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

004.14(B)(i) MEDICAL DIRECTION OF MORE THAN FOUR CONCURRENT PROCEDURES. If the physician is involved in providing direction for more than four concurrent procedures or is performing other services while directing the concurrent

procedures, the concurrent anesthesia services are covered as the technical component of the hospital services. The physician must ensure that a qualified individual performs any procedure in which the physician does not personally participate.

004.14(C) STANDBY ANESTHESIA SERVICES. A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the 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).

004.14(D) NURSE ANESTHETIST. 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 Nebraska Medicaid.

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

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

004.17 HOSPITAL DENTAL SERVICES. When dental treatment is necessary as a hospital inpatient or outpatient service, these services must be provided, billed and reimbursed in accordance with the provisions of 471 NAC 6.

004.18 OTHER ANCILLARY SERVICES.

004.18(A) EMERGENCY ROOM PHYSICIANS' SERVICES. The hospital must 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.

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

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

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

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

005. NON-COVERED SERVICES. The following services are not intended to be an all-inclusive, or exhaustive, list of non-covered services.

005.01 SURGICAL PROCEDURES. The Department does not cover:

(A) Acupuncture;
(B) Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
(C) Angiocardiography, utilizing CO_2 method, supervision and interpretation only;
(D) Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
(E) Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
(F) Artificial Heart Transplant;
(G) Ballistocardiogram;
(H) Basal metabolic rate (BMR);
(I) Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
(J) Circumcision, female;
(K) Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
(L) Extra-intra cranial arterial bypass for stroke;
(M) Fabric wrapping of abdominal aneurysm;
(N) Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
(O) Fascia lata by stripper when used as a treatment for lower back pain;
(P) Hypogastric or presacral neurectomy (independent procedure);
(Q) Hysterotomy, non-obstetrical, vaginal;
(R) Icterus index;
(S) Ileal bypass or any other intestinal surgery for the treatment of obesity;
(T) Kidney decapsulation, unilateral and bilateral;
(U) Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;
(V) Ligation of internal mammary arteries, unilateral or bilateral;
(W) Ligation of thyroid arteries (independent procedure);
(X) Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;
(Y) Omentopexy for establishing collateral circulation in portal obstruction;
(Z) Perirenal insufflation;

(AA) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
(BB) Protein bound iodine (PBI);
(CC) Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
(DD) Refractive keratoplasty including keratomileusis, keratophakia, and radial keratotomy;
(EE) Reversal of tubal ligation or vasectomy;
(FF) Sex change procedures;
(GG) Splanchicectomy, unilateral or bilateral, when used as a treatment for hypertension;
(HH) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes or ovaries, one or both;
(II) Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension; and
(JJ) Uterine suspension, with or without presacral sympathectomy.

005.02 OBSOLETE TESTS. Obsolete tests may be covered only if the physician who performs the test justifies the medical necessity for the test. The Department will determine that satisfactory medical necessity exists from the physician's justification. The Department does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:

(A) Amylase, blood isoenzymes, electrophoretic;
(B) Chromium, blood;
(C) Guanase, blood;
(D) Zinc sulphate turbidity, blood;
(E) Skin test, cat scratch fever;
(F) Skin test, lymphopathia venereum;
(G) Circulation time, one test;
(H) Cephalin flocculation;
(I) Congo red, blood;
(J) Hormones, adrenocorticotropin quantitative animal tests;
(K) Hormones, adrenocorticotropin quantitative bioassay;
(L) Thymol turbidity, blood;
(M) Skin test, actinomycosis;
(N) Skin test, brucellosis;
(O) Skin test, leptospirosis;
(P) Skin test, psittacosis;
(Q) Skin test, trichinosis;
(R) Calcium, feces, 24-hour quantitative;
(S) Starch; feces, screening;
(T) Chymotrypsin, duodenal contents;
(U) Gastric analysis pepsin;
(V) Gastric analysis, tubeless;
(W) Calcium saturation clotting time;
(X) Capillary fragility test (Rumpel-Leede);
(Y) Colloidal gold;
(Z) Bendien's test for cancer and tuberculosis;
(AA) Bolen's test for cancer; and

(BB) Rehfuss test for gastric acidity.

005.03 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.

005.04 EXPERIMENTAL AND INVESTIGATIONAL SERVICES. The Department does not cover medical services which are considered investigational 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, the Department prohibits payment for these services.

005.04(A) RELATED SERVICES. The Department does not pay for associated or adjunctive services that are directly related to non-covered experimental/investigational services.

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

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

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

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

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

(iv) 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 Food and Drug Administration oversight and regardless of whether an Institutional Review Board (IRB) process or protocol is required at any one particular institution.

005.05 CUSTODIAL OR RESPITE CARE. The Department does not cover hospital services that are custodial or respite care.

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

005.07 PROSTHETICS. The Department does not cover external powered prosthetic devices.

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

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

005.10 HOSPITAL ACQUIRED CONDITIONS. The Department will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that the Department will, at a minimum, identify as a hospital acquired conditions (HAC), those diagnoses codes that have been identified as Medicare hospital acquired conditions (HAC) when not present on hospital admission.

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

005.12 NON-COVERED PORTABLE X-RAY SERVICES. The Department does not cover the following portable x-ray services:

(A) Procedures involving fluoroscopy;
(B) Procedures involving the use of contrast media;
(C) Procedures requiring the administration of a substance to the patient or injection of a substance into the patient or special manipulation of the patient;
(D) Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
(E) Procedures requiring special technical competency or special equipment or materials;
(F) Routine screening procedures; and

(G) Procedures which are not of a diagnostic nature.

006. LIMITATIONS AND REQUIREMENTS FOR CERTAIN SERVICES.

006.01 PRIOR AUTHORIZATION PROCEDURES. The physician must request prior authorization for these services in writing or the standard electronic Health Care Services

Review: Request for Review and Response transaction (ASC X12N 278) prior to providing the service.

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

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

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

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

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

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

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

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

006.03 MINOR SURGICAL PROCEDURES. Reimbursement for excision of lesions of the skin or subcutaneous tissues includes all services and supplies necessary to provide the

service. The Department does not make additional reimbursement for suture removal to the physician who performed the initial service or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the physician who provided the initial service, the Department may approve separate payment for the suture removal.

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

006.04(A) INTESTINAL BY-PASS SURGERY. The Department does not consider this procedure to be reasonable and necessary, and does not cover the procedure.

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

(a) Medically appropriate for the individual; and
(b) Performed to correct an illness which caused the obesity or was aggravated by the obesity.

006.04(B)(i) This procedure must be performed at a facility that is a Bariatric Surgery Center of Excellence.

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

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

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

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

006.06 STERILIZATIONS.

006.06(A) COVERAGE RESTRICTIONS. Nebraska Medicaid is prohibited from paying for sterilization of individuals:

(i) Under the age of 21 on the date the client signs Form MMS-100; or

(ii) Legally incapable of consenting to sterilization.

006.06(B) COVERAGE CONDITIONS. The Department covers sterilizations only when:

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

(ii) The client is advised at the outset and before the request or receipt of their consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized;

(iii) Clients whose primary language is other than English must be provided with the required elements for informed consent in their primary language;

(iv) Suitable arrangements must be made to communicate the required elements of informed consent to an individual who is blind, deaf, or otherwise handicapped.

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

(1) Legally effective informed consent is obtained on Form MMS-100: Consent Form from the client on whom the sterilization is to be performed. The surgeon must 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 the Department. The consent is effective for 180 days from the date Form MMS-100 is signed.

006.06(C)(i) EXCEPTION. 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 he or she 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.

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

(a) A clear explanation of the procedures to be followed;

(b) A description of the attendant discomforts and risks that may follow the procedure, including an explanation of the type and possible effects of an anesthetic to be used;

(c) A description of the benefits to be expected;

(d) Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;

(e) An offer to answer any questions concerning the procedures; and

(f) An instruction that the individual is free to withhold or withdraw their consent to the sterilization at any time before the sterilization without prejudicing their future care and without loss of other project or program benefits to which the client might otherwise be entitled;

(g) Advice that the sterilization will not be performed for at least 30 days, except under the circumstances; and
(h) The individual to be sterilized must be permitted to have a witness of her or his choice present when informed consent was obtained.

006.06(C)(ii)(1) CLIENT RESPONSIBILITY. This information is shown on Form MMS-100, which must be completed by the client.

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

(i) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and
(ii) The individual or her representative, if any, has signed Form MMS-101 acknowledging receipt of that information.

006.07(A) EXCEPTION. The Department 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 the patient determined prior acknowledgment was not possible. The physician must also include certification of the emergency.

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

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

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

006.08 ABORTIONS. The Department covers abortions when the life of the mother would be endangered if the fetus were carried to term for which federal financial participation is currently

available under Title XIX of the Social Security Act and the Nebraska Medicaid State Plan. A physician must certify the diagnosis by medical reports which include the name and address of the client. The treating physician must request and receive prior authorization before providing the service from the Department before providing the service. If approved, the Department will send 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.

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

006.10 LABOR AND DELIVERY. The Department covers 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. Postpartum services are covered for a 60-day period beginning on the day the pregnancy ends, and any remaining days in the month in which the 60th day falls, for women who were eligible for, applied for, and received medical assistance on the day the pregnancy ends. After the infant is delivered, the infant is treated as a separate patient for reimbursement purposes.

006.10(A) PHYSICIANS' SERVICES. The Department covers routine prenatal care, delivery, six weeks post-partum care, and routine urinalysis as a package service for physicians in accordance with 471 NAC 18. The Department does not reimburse hospitals for any physicians' services included in the package service.

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

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

006.11 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 the Department. The Department does not cover services when the detoxification needs of an individual no longer require an inpatient hospital setting.

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

006.12(A) INVASIVE OSTEOGENIC STIMULATION. Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or

by implantation of a coiled cathode wire into the fracture site. For percutaneously-placed cathodes, the power supply is externally placed and the leads connected to the inserted cathodes. For the implanted cathode, the power pack is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. The Department covers use of the invasive device only for non-union of long bone fractures. The Department considers non-union to exist only after six months or more have elapsed without the fracture healing.

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

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

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

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

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

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

006.15 THERAPEUTIC SERVICES. The Department may cover therapeutic services 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 will be provided for:

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

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

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

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

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

006.16(B)(i) CARDIAC REHABILITATION EXERCISE PROGRAM. Hospital outpatient services in connection with a cardiac rehabilitation exercise program are considered reasonable and necessary only during that period of time when the patient's condition is such that the exercises can only be carried out safely under the direct, continuing supervision of a physician, and in a hospital environment. The monitoring required in these programs must be carried out by a hospital-employed nurse trained in cardiac rehabilitation with a physician overseeing the monitoring. Although on occasion physical therapists 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.

006.16(B)(ii) COVERAGE LIMIT. Coverage is limited to 12 weeks (or 36 sessions) of a monitored exercise program. For coverage beyond a maximum duration of 12 weeks

(or 36 sessions), the provider must submit documentation supporting the patient's need for additional services. Documentation must include:

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

006.17 MEDICAL TRANSPLANTS. The Department covers 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 Department will determine whether the transplant is medically necessary or non-experimental. The Department will cover transplantation services when performed in a facility approved by Centers for Medicaid and Medicare as meeting coverage criteria.

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

(i) 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;
(ii) The patient's Nebraska Medicaid number;
(iii) Name of hospital, city, and state where the service(s) will be performed;
(iv) Name of physician(s) who will perform the surgery, if other than physician requesting authorization; and
(1) If authorization is requested for a liver or heart transplant, in addition to the above information, two physicians must also supply the following statement: 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.

006.17(B) SERVICES FOR A NEBRASKA MEDICAID-ELIGIBLE DONOR. The Department covers medically necessary services, including laboratory tests directly related to the transplant, for the Nebraska Medicaid-eligible donor to a Nebraska Medicaid-eligible client. The services must be directly related to the transplant.

006.17(C) SERVICES FOR A NEBRASKA MEDICAID-INELIGIBLE DONOR. The Department covers medically necessary services, including laboratory tests directly

related to the transplant, for the Nebraska Medicaid-ineligible donor to a Nebraska Medicaid-eligible client. The services must be directly related to the transplant and must directly benefit the Nebraska Medicaid transplant client. Coverage of treatment for complications related to the donor is limited to those that are reasonably medically foreseeable. Claims must be submitted under the Nebraska Medicaid-eligible client's case number.

006.17(D) The Department reserves the right to request any medical documentation from the patient's record to support and substantiate claims submitted for payment.

006.17(E) The Department is the payor of last resort.

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

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

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

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

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

006.19(A) The hospital room charge is considered the technical component of the visit and must be billed on Form CMS-1450 (UB-92).

006.20 INFANT APNEA MONITORS. The Department 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.

006.20(A) MEDICAL GUIDELINES FOR THE PLACEMENT OF HOME INFANT APNEA MONITORS. The Department covers home infant apnea monitoring services for infants,

defined as birth through completion of one year of age, who meet one of the following criteria:

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

(ii) Symptomatic preterm infants;

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

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

006.20(B) APPROVAL OF HOME INFANT APNEA MONITOR SERVICE PROVIDERS. The Department covers 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.

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

(i) The number of apnea episodes during the previous prescription period;

(ii) The results of any tests performed during the previous prescription period;

(iii) Additional length of time needed; and

(iv) Any additional information the physician may wish to provide.

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

006.20(E) COVERED AND NON-COVERED COMPONENTS. The Department does not cover monitors that do not use rechargeable batteries. The Department 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.

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

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

006.21 HOME PHOTOTHERAPY. The Department 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. 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.

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

006.21(A)(i) The following conditions must be met prior to initiation of home phototherapy:

(a) 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;
(b) Required laboratory studies have been performed, including, complete blood count (CBC), blood type on mother and infant, direct Coombs, direct and indirect bilirubin;
(c) The physician certifies that the parent or caregiver is capable of administering home phototherapy;
(d) Parent or caregiver have successfully completed training on use of the equipment; and
(e) 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 or replacement service available.

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

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

(i) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
(ii) A minimum of one daily visit to the home by a licensed or certified "health care professional" as identified by the supplier in the "Coordination Plan." The daily visits must include:

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

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

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

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

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

(i) Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;
(ii) A minimum of one daily visit to the home by a licensed or certified "health care professional" is required. The daily visits must include:
(1) A brief home assessment; and
(2) Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available. An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill Medicaid directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home.
(iii) Complete caregiver training on use of equipment and completion of necessary records.

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

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

(1) An overview of the services provided, including the provider's charge for the services;
(2) Descriptions and literature on the equipment and all supplies and accessories provided;
(3) Copies of all forms, instructions, and record sheets for client use;

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

006.22(A) The provider must notify the Department of any changes in the coordination plan. After review of the coordination plan, the provider may be required to amend the coordination plan.

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

006.23 AMBULATORY ROOM AND BOARD. The Department covers ambulatory room and board as a related transportation and as follows:

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

006.23(A)(i) PROVIDER RE-APPROVAL. Each hospital approved by the Department to provide ambulatory room and board services must 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.

006.23(B) GUIDELINES. The Department covers ambulatory room and board services as follows:
(1) Ambulatory room and board services must be necessary to secure Nebraska Medicaid coverable services, including medical examinations or treatment.
(2) The Department covers meals when receipt of Nebraska Medicaid coverable services requires the client to be away from their home for 12 hours or longer;
(3) The Department covers lodging when an out-of-town overnight stay is necessary while receiving Nebraska Medicaid coverable services or if coverage of ambulatory room and board services will prevent a hospital inpatient stay; and

(4) The Department covers meals and lodging for up to one day before or after receiving services if extensive travel is necessary.
(5) The Department covers up to one person who accompanies the client when the client is physically or mental unable to travel or wait alone. For example, a child's parent or guardian.

006.23(B)(i) Payment for ambulatory room and board services outside these guidelines must be approved by the Department staff.

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

006.23(D) BILLING AND PAYMENT. The hospital must bill for ambulatory room and board services provided by a Department-enrolled hospital as an outpatient service on the appropriate claim form or electronic format and the appropriate Healthcare Common Procedure Coding System procedure codes. Payment will be made using a hospital-specific rate. Payment to the hospital must not exceed its charge for services provided to the general public.

007. BILLING AND PAYMENT FOR HOSPITAL SERVICES.

007.01 PAYMENT.

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

007.01(B) SPECIFIC PAYMENT REQUIREMENTS.

007.01(B)(i) OUTPATIENT SERVICES. The Department provides reimbursement for hospital outpatient services provided to Nebraska Medicaid eligible clients on a prospective basis in accordance with the rate methodology for Outpatient Hospital and Emergency Room Services. Reimbursement for the following services is included in the prospective rate payment for hospital inpatient services:

(a) Technical Component of Hospital Outpatient Radiology Services;
(b) Non-Patient Radiology Services;
(c) Anesthesiology:
  (i) Technical Component of Medical Direction of Four or Fewer Concurrent Procedures for hospital outpatient;
  (ii) Technical component of outpatient anesthesiology services provided by anesthetists who are not employees of a physician; and
(d) Medical Transplants, hospital charges for ambulatory stays.

007.01(B)(i)(1) This list is not intended to be an exclusive list of services that are reimbursed as a part of the hospital prospective payment for outpatient services.

Other services that are considered to be included within the scope of services that are reimbursed as a part of the prospective payment for outpatient services include, but are not limited to, the following:

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

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

(a) Hospital observation services when the client is thereafter admitted as an inpatient of the same hospital;
(b) Hospital outpatient or emergency room services when the client is thereafter admitted as an inpatient of the same hospital before midnight of the same day;
(c) Non-physician inpatient services and Items:
    (i) Outpatient and emergency room services provided by the hospital before admission; and
    (ii) Outpatient or inpatient services provided by another hospital or free-standing medical facility to an inpatient of the original admitting facility.
    (iii) Payment for durable medical equipment, orthotics, and prosthetics, etc., for hospital inpatients is included in the hospital's payment for inpatient services.
(d) Labor and delivery: The Department utilizes the current Medicare methodology in accounting for labor and delivery charges on the Medicare cost report;
(e) Technical component of inpatient clinical laboratory services: The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate;
(f) Technical component of inpatient anatomical pathology services: The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate;
(g) Technical component of hospital inpatient radiology services: These costs may be included on the hospital's cost report to be considered in calculating the hospital's payment rate;
(h) Anesthesiology:
    (i) Technical component of medical direction of four or fewer concurrent procedures for hospital;
    (ii) Technical component of inpatient anesthesiology services provided by anesthetists who are not employees of a physician;
(i) Inpatient dialysis: The hospital may include the costs of inpatient dialysis services on it cost report to be considered in calculation the hospital payment rate.
(j) Pre-Admission Testing;
(k) Medical transplants:
    (i) Hospital inpatient services, including procurement costs;
    (ii) Technical component of inpatient laboratory and diagnostic and therapeutic radiology;

(l) Infant apnea monitoring services provided to an inpatient.

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

(a) Services which are included by a hospital in the Medicare cost report; or
(b) Services which are customarily reimbursed as a part of the prospective payment for inpatient services.

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

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

007.01(B)(v) INPATIENT ADMISSION AFTER OUTPATIENT SERVICES. A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. Inpatient services, for billing and payment purposes, includes the following:

(a) Non-physician outpatient services rendered on the day of admission or during the inpatient stay;
(b) Diagnostic services rendered up to three days before the day of admission; and
(c) Admission related non-diagnostic 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.

007.01(B)(v)(1) READMISSIONS. The Department adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All Nebraska Medicaid 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 by medical review.

007.01(B)(vi) INTERIM PAYMENT FOR LONG-STAY PATIENTS. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days. To request an interim payment, the hospital must send the appropriate claim form or electronic format to the Department indicating the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days.

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

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

007.01(B)(viii) NON-PAYMENT FOR HOSPITAL ACQUIRED CONDITIONS. The Department 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 the Department is a secondary payor to Medicare.

007.01(B)(ix) OUT-OF-PLAN SERVICES. When Managed Care enrollees are provided hospital inpatient services by Nebraska Medicaid enrolled facilities not under contract with the Department's managed care organizations (MCO), the managed care organizations (MCO) are authorized, but are not required, to pay for the care provided at rates the Department would otherwise reimburse providers.

007.01(B)(x) LOWER LEVELS OF CARE. When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. Medically necessary skilled nursing care must be authorized within 15 days of admission.

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

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

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

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

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

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

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

007.01(D) PAYMENT FOR SERVICES FURNISHED BY A CRITICAL ACCESS HOSPITAL (CAH). The Department reimburses 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 critical access hospitals (CAH), items and services that a critical access hospitals (CAH), provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

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

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

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

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

007.01(F)(i) RECAPTURE OF DEPRECIATION. A hospital which is sold for a profit and has received Nebraska Medicaid payments for depreciation must refund to the Department the lower of:
  (1) The amount of depreciation allowed and paid by the Department; or
  (2) The product of:
    (a) The ratio of Nebraska Medicaid allowed inpatient days to total inpatient days; and
    (b) The amount of gain on the sale as determined by the Medicare.

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

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

007.01(G)(i) REQUEST FOR RATE ADJUSTMENTS. Hospitals may submit a request to the Department for an adjustment to their rates for the following:
  (1) An error in the calculation of the rate;
  (2) Extraordinary circumstances. Extraordinary circumstances are limited to:
    (a) Changes in routine and ancillary costs, which are limited to:
      (i) Intern and resident related medical education costs; and
      (ii) Establishment of a subspecialty care unit;
    (b) Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase; or

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

007.01(G)(ii) ADJUSTMENT CONDITIONS. In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital. If an adjustment is granted, the peer group rates will not be changed. In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital must demonstrate the following:

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

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

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

007.01(J) COST REPORT AUDITS. The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent

public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

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

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

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

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

(i) The provider’s submitted charge; or
(ii) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service.

007.01(N) 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;
(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.

007.01(N)(i) 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 Nebraska Medicaid allowable charges incurred in this type of visit will be paid according to 471 NAC 10.

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

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

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

007.01(S) LIMITATIONS ON PAYMENT FOR HOSPITAL SERVICES.

007.01(S)(i) PLACE OF SERVICE. The department may review, reduce, or deny payment for covered outpatient or emergency room drugs, supplies, or services which could have been provided in a less expensive setting.

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

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

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

007.01(T) THE DEPARTMENT'S SURVEILLANCE AND UTILIZATION REVIEW OF HOSPITAL SERVICES. The Department, or its designee, reviews hospital inpatient services for:

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

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

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

007.01(T)(i)(1) REVIEW FOR ALL SELECTED CASES. Validation will include:

(a) Validation of diagnostic and procedural information and ICD-9-CM coding;
(b) Medical necessity for inpatient admission and procedure(s);
(c) Stability at discharge; and
(d) Quality of care.

007.01(T)(i)(2) PAYMENT REDUCTION. If the Department, or its designee, determines that either admissions or discharges are performed without medical justification, payment for inpatient services may be denied. Payment can be reduced if coding inaccuracies are identified by the Department 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.

007.01(T)(ii) REVIEW ACTIVITIES FOR HOSPITAL INPATIENT SERVICES REIMBURSED ON A PROSPECTIVE PER DIEM BASIS. Hospital inpatient care must be reasonable, medically necessary, and appropriate for the class of care being billed. All hospital inpatient admissions must be certified by the Department 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 or denied.

007.01(T)(iii) 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.

007.02 BILLING.

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

007.02(B) SPECIFIC BILLING REQUIREMENTS. Providers of hospital services must submit claims to the Department on Form CMS-1450.

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

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

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

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

007.02(B)(iii)(1) 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 present on admission (POA), these diagnoses will not be used for All Patient Diagnostic Related Group grouping. The claim will be paid as though any diagnoses included in the list of hospital-acquired conditions (HAC) were not present on the claim. The Department denies payment for any hospital-acquired conditions (HAC) that results in death or serious disability. The Department does not make additional payments for services on inpatient hospital claims that are attributable to hospital-acquired conditions (HAC) and are coded with present on admission (POA) indicator codes "N" or "U". Specifically, for hospitals paid under the:

(i) Diagnostic related group (DRG) payment method, the Department does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).
(ii) Cost to Charges (CCR) payment method, the Department does not pay for charges attributable to the hospital-acquired conditions (HAC).
(iii) 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 the Department can reasonably isolate for nonpayment the portion of the payment directly related to the PPC.

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

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

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

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

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

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

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

007.02(B)(vi)(1)(a) SMALL INSTITUTION. If, because of the small size of the institution, it is impossible to have a properly functioning staff committee, the utilization review (UR) committee must be established under item two 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. At least two members of the committee must be doctors of medicine or osteopathy. The other members may be:

(i) A doctor of medicine or osteopathy;
(ii) A doctor of dental surgery or dental medicine;
(iii) A doctor of podiatric medicine;
(iv) A doctor of optometry; or
(v) A chiropractor.

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

(i) Admissions to the hospital;
(ii) The duration of stays; and
(iii) Professional services provided, including drugs.

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

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

(a) May be made by one member of the utilization review (UR) committee if the practitioner(s) responsible for the patient's care concur with the determination or fail to present their view when given the opportunity; or

(b) In all other cases, must be made by at least two members of the utilization review (UR) committee.

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

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

(i) The hospital's utilization review (UR) committee has determined that an admission or an extended stay is or was not medically necessary;

(ii) The hospital has met the client notification requirements in 471 NAC 10; and

(iii) The Nebraska Medicaid client chooses to remain in the hospital or be admitted to the hospital.

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

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

007.02(B)(vii)(4) RECERTIFICATION OF CONTINUED STAY. Recertification must be made at least every 60 days after initial certification. Psychiatric inpatient care must be certified every 30 days.

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

007.02(B)(ix) SWING BEDS. The Department covers swing beds only for skilled nursing care where a client requires 24-hour professional nursing care.

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

(a) Complete an admission Form MC-9-NF or use the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);
(b) Submit a copy of Form DM-5 or physician's history and physical;
(c) Complete Long Term Care Evaluation; and
(d) Submit all the information to the local office.

007.02(B)(x) ANCILLARY SERVICES. The hospital must bill for ancillary services for swing-bed patients who are eligible for Nebraska Medicaid only. If Medicare is covering the swing-bed services, the facility must not bill the Department for ancillary services.

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

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

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

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

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

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

008.02 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 signed and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing, or evaluating the service furnished. All records must document the following, as appropriate:

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

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