

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

Phase I: Initial introduction of an investigational service into humans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DRG Weight: A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each stable DRG.

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

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

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

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

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

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

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

Low Volume DRG: DRGs with less than 10 claims in the two year claims dataset used to calculate DRG relative weights.

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

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

2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.

Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

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

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

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

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

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

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

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

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

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

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

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

For claims containing secondary diagnoses that are included in the list of HACs in Appendix 471-000-542 and for which the condition was not POA, HAC secondary diagnoses will not be used for AP-DRG grouping. The claim will be paid as though any secondary diagnoses included in the list of HACs in Appendix 471-000-542 were not present on the claim. The Department does not make additional payments for services on inpatient hospital claims that are attributable to HACs and are coded with POA indicator codes "N" or "U". Specifically, for hospitals paid under the:

1. Diagnostic related group (DRG) payment method, the Department does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).
2. Cost to Charges (CCR) payment method, the Department does not pay for charges attributable to the HAC.

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

For complete billing instructions for POA and HAC, see Title 471 NAC Appendix 471-000-542.

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

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

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

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

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