

## CHAPTER 21-000 REHABILITATION CARE IN HOSPITALS

### 21-001 Definitions

Activities of Daily Living: Activities performed by the client relating to self-care, such as bathing, continence, eating, dressing, grooming, mobility, toileting, and transferring.

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.

Initial Evaluation: See 471 NAC 21-003.02A

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.

Rehabilitation Services: Any medical or remedial services recommended by and within the scope of practice under state law of a physicianw, for maximum reduction of physical or mental disability and restoration of a client to the client's best possible functional level.

Rehabilitation Team: A multidisciplinary coordinated team, comprised of individuals described in 471 NAC 21-003.02(i)-(vii), which is responsible for performing the initial evaluation, determining the extent to which rehabilitation is possible, identifying rehabilitation goals, and developing the rehabilitation program.

### 21-002 Provider Requirements

21-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of rehabilitation services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in 471 NAC Chapter 21, the individual provider participation requirements in 471 NAC Chapter 21 shall govern.

21-002.02 Specific Provider Requirements: Rehabilitation services must be provided in a hospital or a distinct part of a hospital that:

- i. Provides rehabilitation services;
- ii. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or, if the hospital is located in another state, the authority responsible for licensing or formal approval in that state;
- iii. Has licensed and certified rehabilitation beds;
- iv. Meets the requirements for participation in Medicare for rehabilitation hospitals; and
- v. Has in effect a utilization review plan which applies to all Medicaid clients.

21-002.02A Provider Agreement: A hospital which provides rehabilitation services shall complete and sign Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider. Each hospital shall have a separate provider agreement (and a separate provider number) for rehabilitation services. The hospital shall submit a description of the rehabilitation program with the provider agreement.

21-002.02A1 Out-of-State Hospital Provider Agreement: In addition to a completed and signed Form MC-20, an out-of-state hospital shall also submit documentation of its certification/accreditation status from the state survey agency in the state where the hospital is located. The Department will not process claims received from an out-of-state hospital until all information required under this section has been received.

Also see 471 NAC 10-010.03J, Out-of-State Hospital Rates, and 10-010.06G, Payment to an Out-of-State Hospital for Outpatient Hospital and Emergency Room Services.

21-002.02B Hospital Level of Rehabilitation Care: The Rehabilitation hospital must provide a hospital level of rehabilitative care. Hospitals with a significant number of rehabilitation team members working on a part time basis must provide evidence to establish that the hospital did, in fact, provide a hospital level of rehabilitative care. Evidence documenting the hospital level of rehabilitative care includes, but is not limited to:

1. Verification that team conferences were held at least once every two weeks;
2. Verification that there was a need for, and involvement of, various allied health professionals; and,
3. Verification of the intensity of the rehabilitative program.

## 21-003 Service Requirements

### 21-003.01 General Requirements

21.003.01A Medical Necessity: Rehabilitation services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A.

21-003.01B Prior Authorization of Medical Rehabilitation Care: Medicaid requires prior authorization of all medical inpatient rehabilitation services to determine the medical necessity, appropriateness of setting, and length of stay. Prior authorization functions, admission reviews, concurrent reviews, and retrospective prepayment reviews are conducted by the peer review organization (PRO), an entity contracted with Medicaid to perform these services. The PRO also performs reconsideration reviews of inpatient hospital denials when requested by the provider.

21-003.01C Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

21-003.01C1 Delayed Enrollment: When a client is in an acute care medical or rehabilitation facility prior to the client's enrollment in Managed Care, the effective date of

enrollment is delayed until the client is discharged from the facility or transferred to a lower level of care. See 482 NAC 2-002.05D.

21-003.01D HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

21-003.02 Covered Services: Medicaid covers rehabilitation services for patients requiring a hospital level of care, and a rehabilitation program which incorporates a multidisciplinary coordinated team approach to upgrade his/her ability to function as independently as possible. A program of this scope usually includes:

- i. Intensive skilled rehabilitation nursing care;
- ii. Physical therapy;
- iii. Occupational therapy; and
- iv. If needed, speech therapy;
- v. Nursing staff to provide general nursing services, and support the other disciplines by monitoring the patient's activities on the nursing floor to ensure that s/he participates in carrying out the activities of daily living utilizing the training received in therapy;
- vi. Ongoing general and, as needed, direct supervision of a physician with special training or experience in the field of rehabilitation (For coverage limitations, billing, and payment of physicians services, see 471 NAC 18-000.); and,
- vii. If needed, a psychologist and/or social worker to help resolve any psychological and social problems which are impeding rehabilitation. (For coverage limitations, billing, and payment of psychological services, see 471 NAC 20-000 and/or 32-000.)

21-003.02A Rehabilitation Evaluation: When a client is admitted to the hospital for rehabilitation care, an assessment must be made of his/her:

- i. Medical condition;
- ii. Functional limitations;
- iii. Prognosis;
- iv. Possible need for corrective surgery;
- v. Attitude toward rehabilitation; and
- vi. The existence of any social problems affecting rehabilitation.

After these assessments are made, the physician, in consultation with the rehabilitation team, decides whether rehabilitation is possible; what the reasonable rehabilitation goals are; and what type of rehabilitation program is required to achieve these goals.

21-003.02A1 Limitations to Coverage of the Initial Evaluation:

21-003.02A1a Duration of Evaluation: When more than 10 days are required to complete the initial evaluation, the Department will carefully review the case to ensure that the additional time was necessary. The Department may request, and the hospital shall submit, documentation showing the necessity of the additional time. Inpatient hospital care is required for this period, and covered under Medicaid if the client's condition warrants a multidisciplinary team evaluation.

21.003.02A1b Identical or Similar Admission Conditions: If, during a previous hospital stay, the client completed a program for essentially the same condition for

which inpatient hospital care is now being provided, the Department covers the initial evaluation period only if:

- i. A change in circumstances has occurred which makes an evaluation reasonable and necessary; or,
- ii. The subsequent admission is to an institution utilizing advanced techniques or technology not available in the first institution.

21-003.02A1c Dementia or Senility: In view of the client's limited rehabilitation potential, a multidisciplinary team evaluation is not considered reasonable and necessary for a client who is demented or severely senile.

21-003.02A2 Mental Confusion: Medicaid does not cover hospitalization for rehabilitation following an evaluation if mental confusion with an inability to learn is the only existing disability. Alternatively, the fact that an individual is "confused" is not a basis for concluding that a multidisciplinary team evaluation is not warranted.

21-003.02B Rehabilitation Program: Medicaid covers hospitalization in cases where the rehabilitation team determines, after the initial evaluation, that a significant practical improvement can be expected in a reasonable period of time. Rehabilitation goals must be realistic and reasonable. Vocational rehabilitation is generally not considered a realistic goal for most clients receiving rehabilitation services under Medicaid. For the majority of clients, the most realistic rehabilitation goal is self-sufficiency in:

1. Bathing;
2. Ambulation;
3. Toileting;
4. Eating;
5. Dressing;
6. Homemaking; or
7. Sufficient improvement in the areas of self-sufficiency to allow the client to live in the community with assistance rather than in an institution.

In assessing the reasonableness of the established goal or the likelihood that the rehabilitation goal can be achieved in a reasonable period of time, considerable weight must be given to the rehabilitation team's judgment, except where experience indicates that in a significant number of cases the team's judgment has proven to be unreliable. An expectation of the attainment of complete independence in the activities of daily living is not necessary, but there must be an expectation of an improvement that would be of a practical benefit to the client.

21-003.02C Team Conferences: Rehabilitation team conferences must be held at least every 2 weeks to:

1. Assess the individual's progress or the problems impeding progress;
2. Consider possible resolutions to the problems;
3. Reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation;
4. Reassess the need for any adjustment in these goals or in the prescribed treatment program; and
5. Develop discharge plans.

Team conferences may be a formal or informal, but must involve interactive discussion regarding the patient. The decisions made during conferences must be recorded in the patient's clinical record. The Department may request, and the hospital shall provide, documentation of team conferences.

21-003.02D Discharge: Medicaid covers a maximum of 3 days to discharge the client. If more than 3 days is needed to safely discharge the client, payment for additional days will be made only when adequate justification for the delayed discharge is submitted to the Department.

### 21-003.03 Non-Covered Services

21-003.03A Poor Candidate for Rehabilitation: When the initial evaluation results in a conclusion that the client is a poor candidate for rehabilitation care, Medicaid limits coverage of inpatient hospital care to a reasonable number of days needed to permit appropriate placement of the client. An intensive rehabilitation program under these circumstances is not considered reasonable and necessary to the treatment of the client's illness or injury.

21-003.03B Further Progress is Unlikely: Rehabilitation services are covered until further progress toward the established rehabilitation goal is unlikely, or further progress may be achieved in a less intensive setting. In making decisions as to whether further progress may be carried out in a less intensive setting, the Department considers:

1. The degree of improvement which has occurred; and
2. The type of program required to achieve further improvement.

When further progress is unlikely, coverage is provided through the time it is reasonable for the physician, in consultation with the rehabilitation team, to have concluded that further improvement would not occur, and effected the client's discharge. Because planning is an integral part of any rehabilitation program and must begin upon the client's admittance to the facility, an extended period of time for discharge action is not reasonable after:

1. Established goals have been reached;
2. A determination has been made that further progress is unlikely; or
3. Care in less intensive setting is appropriate.

### 21-004 Billing and Payment for Chiropractic Services

#### 21-004.01 Billing

21-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 21, the billing requirements in 471 NAC Chapter 21 shall govern.

#### 21-004.01B Specific Billing Requirements

21-004.01B1 Billing Instructions: The provider shall bill Medicaid in accordance with the billing instructions included in this Chapter.

21-004.02 Payment

21-004.02A General Payment Requirements: Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 21, the payment regulations in 471 NAC Chapter 21 shall govern.

21-004.02B Specific Payment Requirements

21-004.02B1 Payment for Inpatient Care: All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem rate will be the sum of the following:

1. The hospital-specific base payment per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.1);
2. The hospital-specific capital per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.2); and
3. If applicable, the hospital's direct medical education per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.3).

Payment for each discharge equals the per diem rate times the number of approved patient days. Payment is made for the day of admission but not for the day of discharge.

21-004.02B2 Payment for Outpatient Hospital and Emergency Room Services: See 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services.

21-005 Evaluation Report and Plan of Care: The hospital shall submit an evaluation report to the Medical Director of the Division of Medicaid and Long-Term Care, or the Medicaid designated contractor, by the end of the second week following admission. The evaluation report must outline a detailed plan of care, and identify time frames applicable to each goal included in the rehabilitation program. The plan of care must contain a detailed staff report describing the client's:

1. Progress;
2. Problems; and
3. Discharge planning, involving possible relocation of the client to the most appropriate setting.

CHAPTER 21-000 REHABILITATION CARE IN HOSPITALS

21-001 Standards for Participation: Rehabilitation services must be provided in a hospital or a distinct part of a hospital that -

1. Provides rehabilitation services;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services Regulation and Licensure or, if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Has licensed and certified rehabilitation beds;
4. Meets the requirements for participation in Medicare for rehabilitation hospitals; and
5. Has in effect a utilization review plan which applies to all Medicaid clients.

21-001.01 Provider Agreement: A hospital which provides rehabilitation services shall complete and sign Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider. Each hospital shall have a separate provider agreement (and a separate provider number) for rehabilitation services. The hospital shall submit a description of the rehabilitation program with the provider agreement.

21-001.01A Out-of-State Hospital Provider Agreement: Each out-of-state hospital shall submit the following:

1. A completed and signed Form MC-20, "Medical Assistance Hospital Provider Agreement;" and
2. Fiscal information regarding payment rates, including whether the hospital is paid on a per diem basis or a diagnosis-related group (DRG) basis by its state Medicaid agency, and the hospital's cost-to-charges ratio for outpatient services.

Department staff shall request information regarding the hospital's certification/accreditation status from the state survey agency in the state where the hospital is located.

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

Also see 471 NAC 10-010.03E, Out-of-State Hospital Rates, and 10-010.06E, Payment to an Out-of-State Hospital for Outpatient Hospital and Emergency Room Services.

~~21-002 Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program (NMMCP): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program (NMMCP). See 471 NAC 3-007 for an explanation of the NMMCP and 471-000-122 for a listing of the NMMCP plans.~~

~~21-002.01 Health Maintenance Organization (HMO) Plans: The NMMCP HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NMMCP HMO plan with the following exceptions:~~

- ~~1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;~~
- ~~2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and~~
- ~~3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed by the HMO, regardless of whether the service is provided by a PCP enrolled with the HMO or a family planning provider outside the HMO.~~

~~Services provided to clients enrolled in an NMMCP HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.~~

~~21-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NMMCP clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider shall obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:~~

- ~~1. Medical Transplants: As define under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and~~
- ~~2. Abortions: As currently defined, abortions require prior authorization by NMAP.~~

~~21-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP shall authorize the services to be provided by the approved provider as needed with the following exceptions:~~

- ~~1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers shall contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.~~
- ~~2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 shall bill for that service by submitting the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) or Form CMS-1500, using HCPCS/CPT procedure codes. These services require referral/ authorization from the client's PCP. The provider shall contact the PCP before providing these services. If a client requires hospitalization for dental treatment or for medical and surgical services billed by submitting the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) or Form CMS-1500, the provider shall contact the PCP for referral/authorization.~~
- ~~3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.~~

~~21-002.03 Mental Health and Substance Abuse Services: Mental health and substance abuse services (MH/SA) are provided by as a managed care benefit for all NMMCP clients. The benefit includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized.~~

~~21-003 Rehabilitation Services: A patient requires a hospital level of care if s/he requires a relatively intense rehabilitation program which requires a multidisciplinary coordinated team approach to upgrade his/her ability to function as independently as possible. A program of this scope usually includes—~~

- ~~1. Intensive skilled rehabilitation nursing care;~~
- ~~2. Physical therapy;~~
- ~~3. Occupational therapy; and~~
- ~~4. If needed, speech therapy.~~

~~A psychologist and/or social worker also participate by helping to resolve any psychological and social problems which are impeding rehabilitation. (For psychological services, see 471 NAC 20-000 and/or 32-000.) The nursing staff supports the other disciplines by monitoring the patient's activities on the nursing floor to ensure that s/he participates to the extent possible in carrying out the activities of daily living utilizing correctly the training received in therapy and provides other needed nursing services. These day-to-day activities are carried out under the continuing general and, as needed, direct supervision of a physician with special training or experience in the field of rehabilitation.~~

~~21-004 Team Conferences: Because the effectiveness of a hospital level rehabilitation program depends on the continuing coordination of all the disciplines involved in the patient's rehabilitation, team conferences must be held regularly (at least every 2 weeks) to—~~

- ~~1. Assess the individual's progress or the problems impeding progress;~~
- ~~2. Consider possible resolutions to the problems;~~
- ~~3. Reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation;~~
- ~~4. Reassess the need for any adjustment in these goals or in the prescribed treatment program; and~~
- ~~5. Develop discharge plans.~~

~~A team conference may be a formal or informal conference, such as patient case rounds; however, a review by the various team members of each others' notes does not constitute a team conference. The decisions made during conferences must be recorded in the patient's clinical record.~~

~~21-005 Hospital Level of Rehabilitation Care: Rehabilitation hospitals and the organized rehabilitation services of short-term hospitals having the capacity to provide a hospital level of rehabilitation care generally find it necessary to have hospital-based physicians and the allied health professionals employed on a full-time basis. If a significant number of a hospital's rehabilitation team work on a part-time basis the Department may question whether the hospital has the capacity to provide the level of rehabilitation care justifying hospitalization. Before the Department pays claims received from this type of hospital, it must establish that the hospital did, in fact, provide a hospital level of rehabilitative care by verifying that team conferences were held on a regular basis and that there was a need for and involvement of various allied health professionals in the patient's treatment program on a relatively intense basis.~~

~~The Department may request documentation of team conferences; the hospital shall submit the requested documentation before the Department pays the claim.~~

~~21-006 Rehabilitation Evaluation: When a client is admitted to the hospital for rehabilitation care, an assessment must be made of his/her~~

- ~~1. Medical condition;~~
- ~~2. Functional limitations;~~
- ~~3. Prognosis;~~
- ~~4. Possible need for corrective surgery;~~
- ~~5. Attitude toward rehabilitation; and~~
- ~~6. The existence of any social problems affecting rehabilitation.~~

~~After these assessments are made, the physician in consultation with the rehabilitation team decides whether rehabilitation is possible; what the reasonable rehabilitation goals are; and what type of rehabilitation program is required to achieve these goals.~~

~~While evaluations usually require between 7 to 10 days, on occasion they may require more. When more than 10 days are required, the Department will carefully review the case to ensure that the additional time was necessary. The Department may request documentation to ensure that the additional time was necessary; the hospital shall submit the requested documentation before the Department pays the claim. Inpatient hospital care is required for this period and reimbursable under NMAP if the client's condition warrants a multidisciplinary team evaluation.~~

~~21-006.01 Limitations to Reimbursement for Initial Evaluation: The fact that a client has received therapy before his/her admission to a hospital for rehabilitative services does not in and of itself preclude reimbursement for the initial evaluation period. If, during a previous hospital stay, the client completed a program for essentially the same condition for which inpatient hospital care is now being provided, the Department makes reimbursement for the evaluation period only if some intervening circumstance has occurred which makes an evaluation reasonable and necessary, or the subsequent admission is to an institution utilizing advanced techniques or technology not available in the first institution.~~

~~21-007 Mental Confusion: The fact that an individual is "confused" is not a basis for concluding that a multidisciplinary team evaluation is not warranted. Many individuals who have had cardiovascular accidents (CVA's) suffer both limited mental attention span and reduced comprehension with a resulting problem in communication. With an intensive rehabilitation program, it is sometimes possible to correct or significantly alleviate both the mental and physical problems. The Department does not cover hospitalization for rehabilitation following an evaluation if mental confusion with an inability to learn is the only existing disability as a result of the CVA. In view of the client's limited rehabilitation potential, a multidisciplinary team evaluation is not considered reasonable and necessary for a client who is demented or severely senile.~~

~~21-008 Rehabilitation Program: The Department makes reimbursement after the initial evaluation period when the rehabilitation program established requires the involvement of various paramedicals on a relatively intense basis and the goals established are realistic and reasonable. While there may be a few instances when an intense rehabilitation program may enable the Medicaid client to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most clients receiving rehabilitation services under NMAP. For the majority of clients, the most realistic rehabilitation goal is self-sufficiency in—~~

- ~~1. Bathing;~~
- ~~2. Ambulation;~~
- ~~3. Toileting;~~
- ~~4. Eating;~~
- ~~5. Dressing;~~
- ~~6. Homemaking; or~~
- ~~7. Sufficient improvement in the areas of self-sufficiency to allow the client to live at home with family assistance rather than in an institution.~~

~~In assessing the reasonableness of the established goal, i.e., the likelihood that the rehabilitation goal can be achieved in a reasonable period of time, considerable weight must be given to the rehabilitation team's judgment, except where experience indicates that in a significant number of cases the team's judgment has proven to be unreliable.~~

~~21-008.01 Reimbursement for Rehabilitation Services: The Department makes reimbursement for hospitalization after the initial evaluation only in those cases where the initial evaluation results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time. An expectation of the attainment of complete independence in the activities of daily living is not necessary, but there must be an expectation of an improvement that would be of a practical benefit to the client.~~

#### 21-009 Limitations to Reimbursement for Rehabilitation Services

~~21-009.01 When the Client Is a Poor Candidate for Rehabilitation: When the initial evaluation results in a conclusion that the client is a poor candidate for rehabilitation care, the Department limits reimbursement for inpatient hospital care to a reasonable number of days needed to permit appropriate placement of the client. An intensive rehabilitation program under these circumstances is not considered reasonable and necessary to the treatment of the client's illness or injury.~~

~~21-009.02 When Further Progress is Unlikely: Reimbursement is made until the time that further progress toward the established rehabilitation goal is unlikely or further progress may be achieved in a less intensive setting. In making decisions as to whether further progress may be carried out in a less intensive setting, the Department considers—~~

- ~~1. The degree of improvement which has occurred; and~~
- ~~2. The type of program required to achieve further improvement.~~

~~In some cases it may be appropriate to conclude that a client who has improved to the point where s/he can take a few steps with a walker will continue to improve under an outpatient program. There are other situations where further improvement in the client's ability to function relatively independently in the activities of daily living may be expected to be achieved only if a multidisciplinary team effort is continued.~~

~~When further progress is unlikely, the cut-off point for payment is not the last day on which improvement actually did occur, but payment is made through the time it is reasonable for the physician in consultation with the rehabilitation team to have concluded that further improvement would not occur and effected the client's discharge. Because planning is an integral part of any rehabilitation program and must begin upon the client's admittance to the facility, an extended period of time for discharge action is not reasonable after—~~

- ~~1. Established goals have been reached;~~
- ~~2. A determination has been made that further progress is unlikely; or~~
- ~~3. Care in less intensive setting is appropriate.~~

~~Because the uniqueness of an inpatient hospital level of rehabilitation care is the multidisciplinary coordinated team approach, the Department's coverage determination must consider the total rehabilitation program. For example, while progress may not have been significant in one area, the total rehabilitation program may have been significant.~~

~~21-010 Discharge: When more than three days are required to discharge the client, payment is made for any additional period involved only when adequate justification for the delayed discharge is submitted to the Department.~~

~~21-011 Evaluation Report and Monthly Reports: The hospital shall submit an evaluation report to the Medical Director of the Division of Medicaid and Long-Term Care by the end of the second week after admission. The evaluation report must outline a detailed plan of care with the time frames of goal achievement for the client. If the Department's approval is extended beyond the initial three weeks, the hospital shall submit a monthly report to the Department. The monthly report must contain a detailed staff report describing the client's—~~

- ~~1. Progress;~~
- ~~2. Problems; and~~
- ~~3. Orientation with possible alteration of direction of effort on the part of the rehabilitation team.~~

21-012 Payment for Rehabilitation Services

~~21-012.01 Prior Authorization of Medical Rehabilitation Care: NMAP requires prior authorization of all medical inpatient rehabilitation services before the service is provided to determine the medical necessity, appropriateness of setting, and length of stay. Prior authorization functions, admission reviews, concurrent reviews, and retrospective prepayment reviews are conducted by the peer review organization (PRO), an entity contracted with NMAP to perform these services. The PRO also performs reconsideration reviews of inpatient hospital denials when requested by the provider.~~

~~21-012.02 Payment for Inpatient Care: See 471 NAC 10-010.03, Payment for Inpatient Hospital Services. Rehabilitation services will be paid on a per diem basis whether the services are provided in a distinct part of a hospital or whether the rehabilitation facility is free-standing as specified in 471 NAC 10-010.03E.~~

~~21-012.03 Payment for Outpatient Hospital and Emergency Room Services: See 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services.~~

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21-001 Standards for Participation: Rehabilitation services must be provided in a hospital or a distinct part of a hospital that -

1. Provides rehabilitation services;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services Regulation and Licensure or, if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Has licensed and certified rehabilitation beds;
4. Meets the requirements for participation in Medicare for rehabilitation hospitals; and
5. Has in effect a utilization review plan which applies to all Medicaid clients.

21-001.01 Provider Agreement: A hospital which provides rehabilitation services shall complete and sign Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider. Each hospital shall have a separate provider agreement (and a separate provider number) for rehabilitation services. The hospital shall submit a description of the rehabilitation program with the provider agreement.

21-001.01A Out-of-State Hospital Provider Agreement: Each out-of-state hospital shall submit the following:

1. A completed and signed Form MC-20, "Medical Assistance Hospital Provider Agreement;" and
2. Fiscal information regarding payment rates, including whether the hospital is paid on a per diem basis or a diagnosis-related group (DRG) basis by its state Medicaid agency, and the hospital's cost-to-charges ratio for outpatient services.

Department staff shall request information regarding the hospital's certification/accreditation status from the state survey agency in the state where the hospital is located.

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

Also see 471 NAC 10-010.03E, Out-of-State Hospital Rates, and 10-010.06E, Payment to an Out-of-State Hospital for Outpatient Hospital and Emergency Room Services.

~~21-002 Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program (NMMCP): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program (NMMCP). See 471 NAC 3-007 for an explanation of the NMMCP and 471-000-122 for a listing of the NMMCP plans.~~

~~21-002.01 Health Maintenance Organization (HMO) Plans: The NMMCP HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NMMCP HMO plan with the following exceptions:~~

- ~~1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;~~
- ~~2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and~~
- ~~3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed by the HMO, regardless of whether the service is provided by a PCP enrolled with the HMO or a family planning provider outside the HMO.~~

~~Services provided to clients enrolled in an NMMCP HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.~~

~~21-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NMMCP clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider shall obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:~~

- ~~1. Medical Transplants: As define under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and~~
- ~~2. Abortions: As currently defined, abortions require prior authorization by NMAP.~~

~~21-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP shall authorize the services to be provided by the approved provider as needed with the following exceptions:~~

- ~~1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers shall contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.~~
- ~~2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 shall bill for that service by submitting the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) or Form CMS-1500, using HGPCS/CPT procedure codes. These services require referral/ authorization from the client's PCP. The provider shall contact the PCP before providing these services. If a client requires hospitalization for dental treatment or for medical and surgical services billed by submitting the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) or Form CMS-1500, the provider shall contact the PCP for referral/authorization.~~
- ~~3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.~~

~~21-002.03 Mental Health and Substance Abuse Services Mental health and substance abuse services (MH/SA) are provided by as a managed care benefit for all NMMCP clients. The benefit includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized.~~

~~21-003 Rehabilitation Services:~~ A patient requires a hospital level of care if s/he requires a relatively intense rehabilitation program which requires a multidisciplinary coordinated team approach to upgrade his/her ability to function as independently as possible. A program of this scope usually includes -

- ~~1. Intensive skilled rehabilitation nursing care;~~
- ~~2. Physical therapy;~~
- ~~3. Occupational therapy; and~~
- ~~4. If needed, speech therapy.~~

~~A psychologist and/or social worker also participate by helping to resolve any psychological and social problems which are impeding rehabilitation. (For psychological services, see 471 NAC 20-000 and/or 32-000.) The nursing staff supports the other disciplines by monitoring the patient's activities on the nursing floor to ensure that s/he participates to the extent possible in carrying out the activities of daily living utilizing correctly the training received in therapy and provides other needed nursing services. These day-to-day activities are carried out under the continuing general and, as needed, direct supervision of a physician with special training or experience in the field of rehabilitation.~~

~~21-004 Team Conferences:~~ Because the effectiveness of a hospital-level rehabilitation program depends on the continuing coordination of all the disciplines involved in the patient's rehabilitation, team conferences must be held regularly (at least every 2 weeks) to -

- ~~1. Assess the individual's progress or the problems impeding progress;~~
- ~~2. Consider possible resolutions to the problems;~~
- ~~3. Reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation;~~
- ~~4. Reassess the need for any adjustment in these goals or in the prescribed treatment program; and~~
- ~~5. Develop discharge plans.~~

~~A team conference may be a formal or informal conference, such as patient case rounds; however, a review by the various team members of each others' notes does not constitute a team conference. The decisions made during conferences must be recorded in the patient's clinical record.~~

~~21-005 Hospital Level of Rehabilitation Care:~~ Rehabilitation hospitals and the organized rehabilitation services of short-term hospitals having the capacity to provide a hospital level of rehabilitation care generally find it necessary to have hospital-based physicians and the allied health professionals employed on a full-time basis. If a significant number of a hospital's rehabilitation team work on a part-time basis the Department may question whether the hospital has the capacity to provide the level of rehabilitation care justifying hospitalization. Before the Department pays claims received from this type of hospital, it must establish that the hospital did, in fact, provide a hospital level of rehabilitative care by verifying that team conferences were held on a regular basis and that there was a need for and involvement of various allied health professionals in the patient's treatment program on a relatively intense basis.

~~The Department may request documentation of team conferences; the hospital shall submit the requested documentation before the Department pays the claim.~~

~~21-006 Rehabilitation Evaluation: When a client is admitted to the hospital for rehabilitation care, an assessment must be made of his/her—~~

- ~~1. Medical condition;~~
- ~~2. Functional limitations;~~
- ~~3. Prognosis;~~
- ~~4. Possible need for corrective surgery;~~
- ~~5. Attitude toward rehabilitation; and~~
- ~~6. The existence of any social problems affecting rehabilitation.~~

~~After these assessments are made, the physician in consultation with the rehabilitation team decides whether rehabilitation is possible; what the reasonable rehabilitation goals are; and what type of rehabilitation program is required to achieve these goals.~~

~~While evaluations usually require between 7 to 10 days, on occasion they may require more. When more than 10 days are required, the Department will carefully review the case to ensure that the additional time was necessary. The Department may request documentation to ensure that the additional time was necessary; the hospital shall submit the requested documentation before the Department pays the claim. Inpatient hospital care is required for this period and reimbursable under NMAP if the client's condition warrants a multidisciplinary team evaluation.~~

~~21-006.01 Limitations to Reimbursement for Initial Evaluation: The fact that a client has received therapy before his/her admission to a hospital for rehabilitative services does not in and of itself preclude reimbursement for the initial evaluation period. If, during a previous hospital stay, the client completed a program for essentially the same condition for which inpatient hospital care is now being provided, the Department makes reimbursement for the evaluation period only if some intervening circumstance has occurred which makes an evaluation reasonable and necessary, or the subsequent admission is to an institution utilizing advanced techniques or technology not available in the first institution.~~

~~21-007 Mental Confusion: The fact that an individual is "confused" is not a basis for concluding that a multidisciplinary team evaluation is not warranted. Many individuals who have had cardiovascular accidents (CVA's) suffer both limited mental attention span and reduced comprehension with a resulting problem in communication. With an intensive rehabilitation program, it is sometimes possible to correct or significantly alleviate both the mental and physical problems. The Department does not cover hospitalization for rehabilitation following an evaluation if mental confusion with an inability to learn is the only existing disability as a result of the CVA. In view of the client's limited rehabilitation potential, a multidisciplinary team evaluation is not considered reasonable and necessary for a client who is demented or severely senile.~~

~~21-008 Rehabilitation Program: The Department makes reimbursement after the initial evaluation period when the rehabilitation program established requires the involvement of various paramedicals on a relatively intense basis and the goals established are realistic and reasonable. While there may be a few instances when an intense rehabilitation program may enable the Medicaid client to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most clients receiving rehabilitation services under NMAP. For the majority of clients, the most realistic rehabilitation goal is self-sufficiency in—~~

- ~~1. Bathing;~~
- ~~2. Ambulation;~~
- ~~3. Toileting;~~
- ~~4. Eating;~~
- ~~5. Dressing;~~
- ~~6. Homemaking; or~~
- ~~7. Sufficient improvement in the areas of self-sufficiency to allow the client to live at home with family assistance rather than in an institution.~~

~~In assessing the reasonableness of the established goal, i.e., the likelihood that the rehabilitation goal can be achieved in a reasonable period of time, considerable weight must be given to the rehabilitation team's judgment, except where experience indicates that in a significant number of cases the team's judgment has proven to be unreliable.~~

~~21-008.01 Reimbursement for Rehabilitation Services: The Department makes reimbursement for hospitalization after the initial evaluation only in those cases where the initial evaluation results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time. An expectation of the attainment of complete independence in the activities of daily living is not necessary, but there must be an expectation of an improvement that would be of a practical benefit to the client.~~

#### 21-009 Limitations to Reimbursement for Rehabilitation Services

~~21-009.01 When the Client Is a Poor Candidate for Rehabilitation: When the initial evaluation results in a conclusion that the client is a poor candidate for rehabilitation care, the Department limits reimbursement for inpatient hospital care to a reasonable number of days needed to permit appropriate placement of the client. An intensive rehabilitation program under these circumstances is not considered reasonable and necessary to the treatment of the client's illness or injury.~~

~~21-009.02 When Further Progress is Unlikely: Reimbursement is made until the time that further progress toward the established rehabilitation goal is unlikely or further progress may be achieved in a less intensive setting. In making decisions as to whether further progress may be carried out in a less intensive setting, the Department considers—~~

- ~~1. The degree of improvement which has occurred; and~~
- ~~2. The type of program required to achieve further improvement.~~

~~In some cases it may be appropriate to conclude that a client who has improved to the point where s/he can take a few steps with a walker will continue to improve under an outpatient program. There are other situations where further improvement in the client's ability to function relatively independently in the activities of daily living may be expected to be achieved only if a multidisciplinary team effort is continued.~~

~~When further progress is unlikely, the cut-off point for payment is not the last day on which improvement actually did occur, but payment is made through the time it is reasonable for the physician in consultation with the rehabilitation team to have concluded that further improvement would not occur and effected the client's discharge. Because planning is an integral part of any rehabilitation program and must begin upon the client's admittance to the facility, an extended period of time for discharge action is not reasonable after—~~

- ~~1. Established goals have been reached;~~
- ~~2. A determination has been made that further progress is unlikely; or~~
- ~~3. Care in less intensive setting is appropriate.~~

~~Because the uniqueness of an inpatient hospital level of rehabilitation care is the multidisciplinary coordinated team approach, the Department's coverage determination must consider the total rehabilitation program. For example, while progress may not have been significant in one area, the total rehabilitation program may have been significant.~~

~~21-010 Discharge: When more than three days are required to discharge the client, payment is made for any additional period involved only when adequate justification for the delayed discharge is submitted to the Department.~~

~~21-011 Evaluation Report and Monthly Reports: The hospital shall submit an evaluation report to the Medical Director of the Division of Medicaid and Long-Term Care by the end of the second week after admission. The evaluation report must outline a detailed plan of care with the time frames of goal achievement for the client. If the Department's approval is extended beyond the initial three weeks, the hospital shall submit a monthly report to the Department. The monthly report must contain a detailed staff report describing the client's—~~

- ~~1. Progress;~~
- ~~2. Problems; and~~
- ~~3. Orientation with possible alteration of direction of effort on the part of the rehabilitation team.~~

21-012 Payment for Rehabilitation Services

21-012.01 Prior Authorization of Medical Rehabilitation Care: NMAP requires prior authorization of all medical inpatient rehabilitation services before the service is provided to determine the medical necessity, appropriateness of setting, and length of stay. Prior authorization functions, admission reviews, concurrent reviews, and retrospective prepayment reviews are conducted by the peer review organization (PRO), an entity contracted with NMAP to perform these services. The PRO also performs reconsideration reviews of inpatient hospital denials when requested by the provider.

21-012.02 Payment for Inpatient Care: See 471 NAC 10-010.03, Payment for Inpatient Hospital Services. Rehabilitation services will be paid on a per diem basis whether the services are provided in a distinct part of a hospital or whether the rehabilitation facility is free-standing as specified in 471 NAC 10-010.03E.

21-012.03 Payment for Outpatient Hospital and Emergency Room Services: See 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services.