1. Comply with the standards prescribed by the Secretary of the federal Health and Human Services (HHS) for nursing facilities in 42 CFR 442;
2. Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health standards, under 42 CFR 431.610; and
3. Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.

12-011.04B Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:

1. General nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
2. Maintenance Therapy: facility staff must aid the client as necessary, under the client's therapy program, with programs intended to maintain the function(s) being restored; to include but not limited to augmentative communication devices with related equipment and software
3. Items which are furnished routinely and relatively uniformly to all clients, such as patient gowns, water pitchers, basins, bedpans, etc.;
4. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, bandaids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with relaged components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.);
5. Items which are used by individual clients which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs. traction equipment, alternating pressure pad and pump, other durable medical equipment, etc. not listed in 12-009.05 and 12-009.06;
6. Nutritional supplements and supplies used for oral, parenteral or enteral feeding.
7. Laundry services, including personal clothing;
8. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.
9. Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance;
10. Injections and supplies: including syringes and needles, but excluding the cost of the drug(s) not listed in 12-009.05 and 12-009.06.

12-011.04C Ancillary Services: Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as "routine services." The facility must contract for ancillary services not readily available in the facility.

If ancillary services are provided by a licensed provider or another licensed facility, e.g., physician, dentist, physical/occupational/speech/etc., therapists, etc., the ancillary service provider must submit a separate claim for each client served.

Allowable costs paid to Physical, Occupational and Speech Therapists are limited to reasonable amounts paid for general consulting services plus reasonable transportation costs not covered through direct billing. General consulting services are not client specific, but instead, are staff related. These services include staff education, in-services and seminars.

Respiratory therapy is an allowable cost.

Department-required independent QMRP assessments are considered ancillary services.

12-011.04D Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16-000). Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses (see 471 NAC 24-000), hearing aids (see 471 NAC 8-000), etc.;
3. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7-000;
4. Prostheses (breast, eye, lower and upper limb) as defined in 471 NAC 7-000;
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4-000;
   a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP will not make payment for ambulance service.
   b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy enter are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonable be expected to be provided at the client's residence (including the Nursing Facility).

12-011.04E Payments to Nursing Facility Provider SEPARATE from Per Diem Rates: Items for which payment may be made to -Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below.

To be covered, the client's condition must meet the criteria for coverage for the item outlined in the appropriate Medicaid provider chapter.

1. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use (see 471 NAC 7-000);
2. Air fluidized bed units and low air loss bed units (see 471 NAC 7-000); and
3. Negative Pressure Wound Therapy, See 471 NAC 7-000).

Reimbursement to Nursing Facility providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published at http://www.dhhs.ne.gov/med/provhome.htm (Division of Medicaid and Long-Term Care website). See ATTACHMENT 4.19-B for fee schedule effective date.

12-011.05 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing per local area telephone directory is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of facility. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians, therapists or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
12. Return on equity;

13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts.
15. Revisit fees.

12-011.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination.

12-011.06A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

12-011.06B Total Inpatient Days: In computing the provider's allowable per diem rates, total inpatient days are used. An inpatient day is:

1. A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or
2. A day on which the bed is held for hospital leave or therapeutic home visits.

Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year.

1. Routine Services: Routine ICF/MR services include regular room, dietary, and nursing services; social and active treatment program as required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:
   a) All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
   b) Active treatment: The facility must provide a continuous active treatment program as determined necessary by each client's Interdisciplinary team, including physical therapy, occupational therapy, speech therapy, recreational therapy, and pre-vocational services and supplies to include but limited to augmentative communication devices with related equipment and software, as described in each client's Individual Plan of Care (see 42 CFR 483.440 and 471 NAC 31-001.02);
   c) Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins. bedpans, etc.;
   d) Items stocked at nursing stations or on each floor/home in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, Band Aids, incontinency care products, oxygen and oxygen equipment, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stocking with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, sanitary napkins and related supplies, etc.), etc.;
   e) Items which are used by individual residents but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, and all other durable medical equipment, not listed in 31-007-06B;
   f) Nutritional supplements and supplies used for oral, enteral, or parenteral feeding;
   g) Laundry services, including personal clothing; and
   h) Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.
   i) Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance.
2. Injections: The resident's physician must prescribe all injections. Payment is not authorized for the administration of injections, since giving injections is considered a part of routine nursing care and covered by the long term care facility's reimbursement. Payment is authorized to the drug provider for drugs used in approved injections. Syringes and needles are necessary medical supplies and are included in the per diem rate.

3. Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility must provide transportation to client services that are reimbursed by Medicaid (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.

31-008.03C Ancillary Services: Ancillary services are those services which are either provided by or purchased by an ICF/IDD and are not properly classified as "routine services." The ICF/IDD must contract for ancillary services not readily available in the ICF/IDD.

If ancillary services are provided by a licensed provider, e.g., physician, dentist, etc., the provider must submit a separate claim for each client served.

Occupational therapy, physical therapy, speech pathology, audiology, psychological, and resident transportation services are considered routine operating costs for ICF/IDDs.

Department-required independent QMRP assessments are considered ancillary services.

31-008.03D Payment to ICF/IDD Provider SEPARATE from Per Diem Rates: Items for which payment may be made to ICF/IDD Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item outlined in 471 NAC 7-000.

1. Non-standard wheelchairs and components;
2. Air fluidized bed units and low air loss bed units; and
3. Negative Pressure Wound Therapy.

Reimbursement to ICF/IDD providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published at http://www.dhhs.ne.gov/med/provhome.htm (Division of Medicaid and Long-Term Care website). See ATTACHMENT 4.19-B for fee schedule effective date.

31-008.03E Payments to Other Providers: Items for which payment may be authorized to non-ICF/IDD providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs*, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16-000). *Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc.;
3. Orthoses (e.g. lower and upper limb, foot and spinal) as defined in 471 NAC 7-000;
4. Prostheses (e.g. breast, eye, lower and upper limb) as defined in 471 NAC 7-000;

5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4-000.
   a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP does not make payment for ambulance service.
   b. Non-emergency ambulance transports to physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the ICF/MR).

31-008.04 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15;
5. Travel and entertainment, other than for professional meetings and direct operations of the facility. Costs of motor homes, boats, and other recreational vehicles including operation and maintenance are not allowable expenses;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts. charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;