



ASSISTED LIVING Services Provider Handbook

Aged and Disabled Waiver

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SECTION 1

Introduction

Department of Health & Human Services

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Welcome and Congratulations! You are now a provider of Aged & Disabled Medicaid Waiver Assisted Living service for Home and Community-Based Services administered by the Nebraska Department of Health and Human Services. Thank you for joining our team!

We've designed this handbook to help you with your job. Remember, however, this is not a substitute for the **Service Provider Agreement** signed by you and the DHHS. You may want to review the Service Provider Agreement paying special attention to the "Terms of Agreement" and "General Provider Standards."

As a new partner with DHHS, we want to make sure you know and understand some of our often-used terms:

"DHHS" refers to the Nebraska Department of Health and Human Services – one of three Departments within the Nebraska Health and Human Services System. DHHS's mission is to create and sustain a unified, accessible, caring and competent health and human services system for each Nebraskan. DHHS staff and contractors are charged to work with clients, providers and communities to make sure quality services are delivered to aged persons and adults and children with disabilities.

The **Home and Community-Based Services Medicaid Waiver for Aged Persons and Adults with Disabilities**, sometimes referred to as the Aged and Disabled (A & D) Medicaid Waiver, offers Medicaid-eligible individuals the chance to receive necessary supportive services in the least restrictive and most home-like setting.

You are an important part of the A& D Medicaid Waiver program. You and other service providers enable individuals to maintain independence in their own homes – their units in your assisted living.

Along with your Waiver individuals, you'll work with Services Coordinators, Resource Developers and Social Service Workers. **Services Coordinators** help residents determine their needs and available resources. **Resource Developers** will work with you, the provider, to ensure standards are met and to eliminate gaps and barriers to service delivery. **Social Service Workers** determine Medicaid eligibility and keep everyone informed of changes regarding individuals' eligibility and financial matters such as Share of Cost (SOC).

Services Coordinators and Resource Developers are employed by an agency, which contracts with DHHS to provide Services Coordination and/or Resource Development. Therefore, in addition to DHHS staff and Waiver individuals, you will be working with one or more staff of a contractor such as one of the eight Area Agencies on Aging located throughout the State of Nebraska.

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How to become a Medicaid Waiver Assisted Living Provider

To become a facility providing Medicaid Waiver Assisted Living services for the Home and Community-Based Services Medicaid Waiver, you should have:

- Worked with Nebraska Department of Regulation and Licensure staff and received an Assisted Living license;
- Worked with a DHHS contracted Resource Developer to complete Medicaid Waiver certification including completing: Assisted Living Service Agreement, Provider Release of Information Felony/Misdemeanor Statement and completing the required forms on the Maximus' Portal.
- Provided DHHS Resource Development contractor with your agency's hiring and reporting policies for background checks of the Adult Protective Services Central Registry and the Child Abuse/Neglect Central Register and verification that checks show there are no substantiated or inconclusive reports of abuse or neglect by you and/or your current direct care staff as well as all new hires; and
- Proven you and your direct care staff have not been convicted of or admitted to evidence of crimes against a child or vulnerable adult. Those crimes include but are not limited to, bodily harm, illegal use of a controlled substance or crimes involving moral turpitude.

General Provider Standards

All Home and Community-Based Services waiver providers are Medicaid providers and shall meet the following general provider standards:

1. Follow all applicable Nebraska Health and Human Services policies and procedures
 - a) Bill only for services which are authorized and actually provided
 - b) Submit billing documents after service is provided and within 90 days.
2. Accept payment as payment is full for the agreed upon service(s) unless the client has been assigned a portion of the cost. Provider will not charge clients any difference between the agreed upon rate and private pay rate.
3. Agrees not to provide services, if he/she is the legally responsible relative (i.e., spouse of individual or parent of minor child who is receiving services).
4. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin.



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5. Retain financial and statistical records for six years from date of service provision to support and document all claims.
6. Allow federal, state or local offices responsible for program administration or audit to review service records. Inspections, reviews and audits may be conducted on site.
7. Keep current any state or local license/certification required for service provision.
8. Provide services as an independent contractor, if the provider is an individual, recognizing that he/she/he is not an employee of the Department or of the State.
9. Agree and assure that any false claims (including claims submitted electronically), statements, documents, or concealment of material fact may be prosecuted under applicable state or federal laws.
10. Respect every waiver individual's right to confidentiality and safeguard confidential information.
11. Understand and accept responsibility for the client's safety and property.
12. Not transfer this agreement to any other entity or person.
13. Operate a drug-free workplace.
14. Not use any federal funds received to influence agency or congressional staff.
15. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom he/she/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect.
16. Allow Central Registry checks on himself/herself, family members if appropriate, or if an agency, agree to allow Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect and law violations are in place.
17. Have the knowledge, experience and/or skills necessary to perform the task(s).
18. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, change in client function).
19. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate DHHS staff.
20. Be age 19 or older if an individual provider; or assure that agency staff who assume the following roles are age 19 or older: director, administrator, agency representative for signing legal documents, or provider of in-home client services.



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What Are Medicaid Waiver Assisted Living Services?

Medicaid Waiver Assisted Living Services:

- ➔ Are a broad range of support services
- ➔ Provided in the residents' own living units
- ➔ Allow residents to take charge of their lives and participate in decisions in a home-like environment.

To understand how the process works, let's invent an imaginary Waiver individual, "Jane." First, she must be financially eligible for Medicaid, the Nebraska Medical Assistance Program. A Services Coordinator who determines she meets the level of care required for waiver eligibility then assesses Jane. This will help identify the adequacy of assisted living and other services available under the Home and Community-Based Services Medicaid Waiver.

If "Jane" is determined eligible for Waiver Services and chooses assisted living. The Assisted Living and Jane will work together to develop a **Resident Service Agreement**. This Agreement ensures the Assisted Living "Jane" chooses includes the services she needs as identified in her **Plan of Services and Supports** (Appendix A).

Along with the services required under your Assisted Living license, the following service components are required, based on the individual's assessment, when you become a Medicaid Waiver Provider. All components are to be provided at no additional cost to the individual. Please remember while an Assisted Living must be able to provide all of these services, individuals may not need them all. The Plan of Services and Supports and the Resident Service Agreement are designed to keep the individual as independent as possible. Individuals should be allowed the option to complete any of the components by themselves, if they so choose.

- ➔ **Adult day care/Social Activities** – Structured social, habilitative and health activities geared for the needs of the individual.
 - ➔ A variety of activities must be provided within the assisted living as well as encouraging community involvement.
 - ➔ Offer access to materials to learn of greater community activities (e.g., newspaper, internet, etc.)
 - ➔ Individual preferences for leisure activities should be honored.
 - ➔ Individuals have the choice to participate in daily activities.
- ➔ **Escort Services** - Accompanying or personally assisting an individual who is unable to travel or wait alone. Escort needs are identified during the assessment and should support the outcomes agreed upon in the Plan of Services and Supports.



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- **Essential Shopping** – Obtaining clothing and personal care items for the individual when they are unable to do so for him/herself. This does not include financing the purchases of clothing and personal care items.
- **Health Maintenance Activities** – Non-complex interventions which can safely be performed according to exact directions, which do not require alterations of standard procedure, and for which the results and the individual's responses are predictable (e.g., recording height and weight, monitoring blood pressure, monitoring blood sugar, and providing insulin injections as long as the client is stable and predictable). The need for health maintenance activities is determined on an individual basis.
- **Housekeeping Services** - Cleaning of public areas as well as the individual's living unit, such as dusting, vacuuming, cleaning floors, cleaning the bathroom, making the bed, changing bed linens as soiled but at least weekly, and making clean bath linens available daily. Individuals preferences on how or times housekeeping is done should be honored.
- **Laundry Services** - Washing, drying, folding and returning an individual's clothing to his/her living unit. Dry cleaning costs are the responsibility of the individuals but please assist in arranging for it, if needed. Individuals' preferences on how often this is completed should be honored.
 - If the individual chose to complete this service themselves, options must be provided to meet this preference at no cost to them.
- **Meal Services** – Three meals must be provided per day, seven days per week, to meet individual needs. Additional options must be available for the individual if only one mealtime menu is offered. Snacks must be offered seven days per week and provided upon request between meals. Second helpings of foods served at meals must be allowed, if desired and within dietary restrictions.
 - Individuals have the choice to set where they chose in the dining room and have the option to eat alone in their room.
 - Individuals may provide their own snacks if they chose and can store them in their own apartment.
 - If the individual chose to cook for themselves, a food preparation area must be available to them either in their apartment or a common area.
- **Medication Assistance** – Assistance with administration of prescriptions and non-prescription medications.
 - The individual is given a choice in location where medications may be obtained and administrated.



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- ➔ **Personal Care Services** - Assistance with ADL's (e.g., transferring, dressing, eating, bathing, toileting, and bladder and bowel continence).
 - ➔ Assistance with eating includes opening packages, cutting food, adding condiments, and other activities which the individual is unable to perform for his/herself in preparing to eat the food. If the individual is unable to eat independently, the assisted living shall feed them or shall assure other arrangements are made for this care.
 - ➔ Individual preferences for bathing should be honored (e.g., time and days). Extra fees should not be charged for additional baths.
 - ➔ Personal care will be provided to the individual in a manner in which they maintain as much independence and privacy as possible. The amount and degree of personal care services is determined on an individual basis.
- ➔ **Transportation Services** –Transporting, or making arrangements for transporting an individual to and from local community resources identified during the assessment and included in the Plan of Services and Supports as directly contributing to the ability of the individual to remain in the assisted living.
 - ➔ Medical and non-medical transportation must be provided or arranged by the assisted living.
 - ➔ The assisted living must provide 5 round trip medical appointments per month.



SECTION 3

Provider Duties and Responsibilities

To receive Medicaid payments, an Assisted Living must be licensed as such and certified as a Medicaid Waiver Assisted Living Provider according to DHHS Rules and Regulations.

In your role as a Medicaid Waiver Services Provider, you will:

- Ensure there are written **Resident Service Agreements** for each individual that was developed jointly with his/her Services Coordinator, the assisted living staff and the individual.
- **Resident Service Agreements** must include:
 - Services to be provided by the assisted-living facility and from other sources, how often and when the services are provided and by whom, to meet the needs of individuals;
 - Rights and responsibilities of the facility and of the individual;
 - Costs of services and terms of payment; and
 - Terms and conditions of continued residency.
- Review and revise the **Resident Service Agreement** with the individual and his/her Services Coordinator at least annually but more often if services or medical information need to be added or changed. You also need to keep his/her Services Coordinator informed of changes in the individual's condition, transfers, etcetera.
- Submit copies of original and revised **Resident Service Agreements** to the individual and his/her Services Coordinator;
- Attend training provided by DHHS staff on billing procedures, service provision, etcetera;
- Provide a private living unit with bath (toilet and sink) for each individual receiving Waiver Services;
- Only upon "special request" from the residents involved, provide a semiprivate living unit. The Services Coordinator must get written consent from the residents and document their preference by using a **Client Consent for Multiple Occupancy** (Appendix D). Prior to providing a semiprivate room, you must have a properly completed and signed consent form on record; and
- If providing Medicaid Waiver Assisted Living Services within a nursing facility, have Waiver certification of separately located areas to include separate dining and common areas.

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By signing the Service Provider Agreement, you have agreed to:

- ➔ Participate as a member of the individual/family's team;
- ➔ Make available each service component required to meet individuals' needs as noted in their **Plan of Services and Supports** and **Resident Service Agreements**;
- ➔ Report any suspected abuse or neglect to Adult Protective Services by calling the Adult Protective Services/Child Protective Services Hotline at **1-800-652-1999**;
- ➔ Respect every resident's right to confidentiality;
- ➔ Respect and accept responsibility for each resident's safety and property;
- ➔ Certify that direct care staff have:
 - 1) Training and/or experience in working with adults in a health care or social setting
 - 2) Knowledge of first aid and current cardiopulmonary resuscitation (CPR) certification
 - 3) The ability to recognize distress and signs of illness in individuals
 - 4) Knowledge of available medical resources; and
 - 5) Access to information on each individual's physician and emergency medical contacts; and
- ➔ Keep the following information in each individual's file for a minimum of four years:
 - ➔ The current **Resident Service Agreement**;
 - ➔ The current **Plan of Services and Supports**;
 - ➔ Phone numbers of emergency contacts and the individual's physician's name and telephone number;
 - ➔ Supporting documentation for provision of services for each individual served under the Waiver; and
 - ➔ Documentation determined necessary by DHHS to support the selection and provision of services included in the **Plan of Services and Supports**.

You have also agreed to:

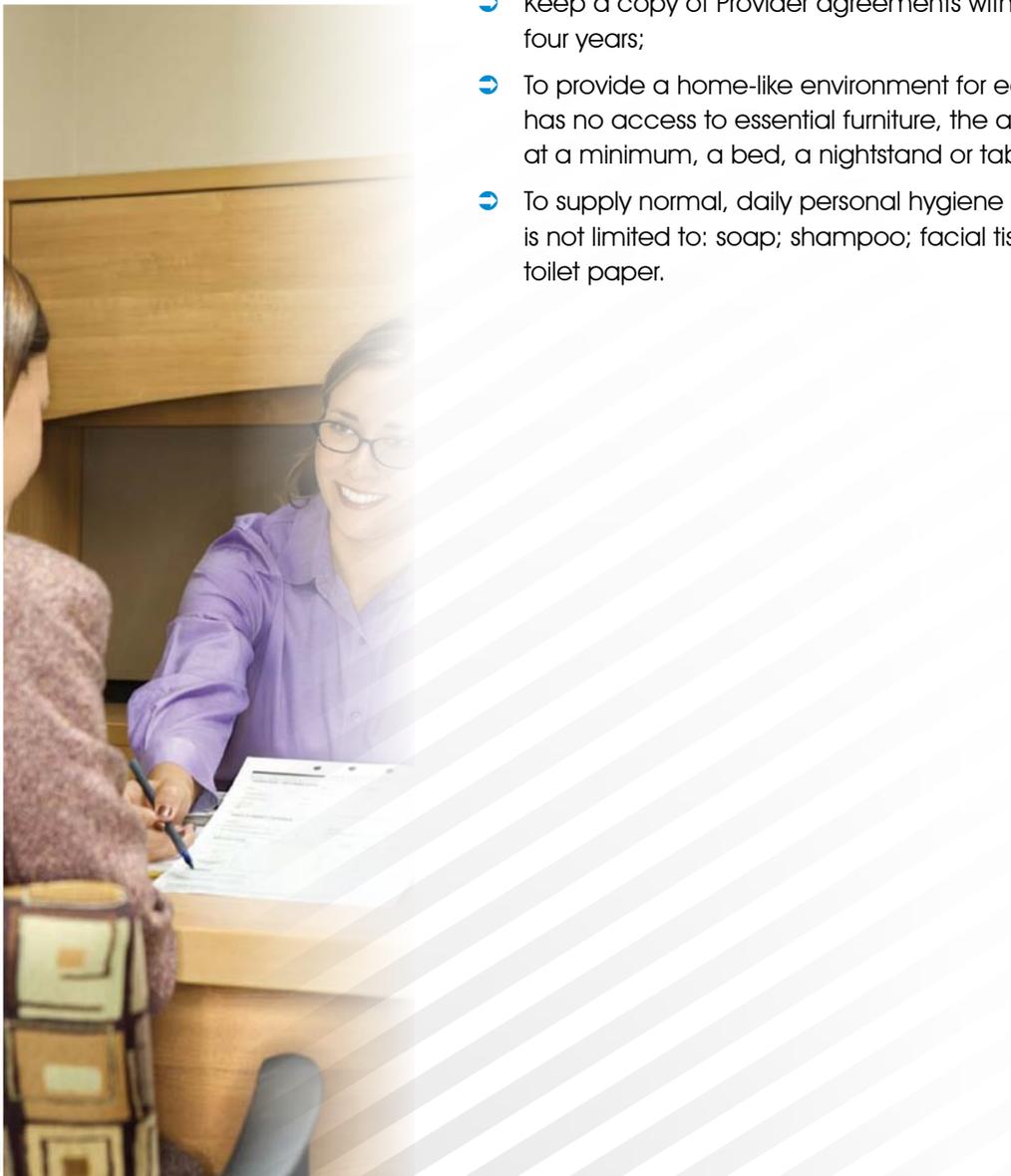
- ➔ Bill only for days when services were authorized;
- ➔ Submit billing documents within 90 days after services are provided (see Section 6 for instructions to complete the required billing forms);
- ➔ **Not** provide services to any individual for whom a facility owner or administrator is his/her spouse;

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- ➔ Keep the assisted living license and Waiver certification current;
- ➔ Reserve the right to discharge any individual whose personal care needs exceed, for more than a temporary period, a level beyond your assisted living's service capability;
- ➔ Work with the Services Coordinator to arrange for alternative services if it becomes necessary to discharge an individual;
- ➔ Report the death of any individual in accordance with the procedures of the "Home and Community-Based Services Waiver Death Review Committee" no later than the next DHHS working day following the resident's death;
- ➔ Keep a copy of Provider agreements with DHHS on file for a minimum of four years;
- ➔ To provide a home-like environment for each individual. If the Waiver individual has no access to essential furniture, the assisted living will provide, at a minimum, a bed, a nightstand or table and a chair; and
- ➔ To supply normal, daily personal hygiene items. This includes at a minimum but is not limited to: soap; shampoo; facial tissue; dental hygiene products; and toilet paper.



SECTION 4

Department Responsibilities

As a partner with the Nebraska Department of Health and Human Services, your assisted living provides individuals with the best possible selection of services. DHHS Services Coordinators or those of agencies contracting with DHHS to provide Services Coordination and Resource Developers can help you address the needs of your individuals and assist you and your staff in your efforts to receive payment for those services. DHHS takes the responsibility to:

- ➔ Contract with you annually to ensure all applicable Federal, State and local laws and regulations are met;
- ➔ Provide you with a detailed, written description which clearly defines the parameters of service delivery including:
 - ➔ The amount and frequency of service provision;
 - ➔ Specific service components authorized; and
 - ➔ Any applicable time limitations;

To be eligible for support through the Aged and Disabled Medicaid Waiver, a potential individual must meet the following general criteria:

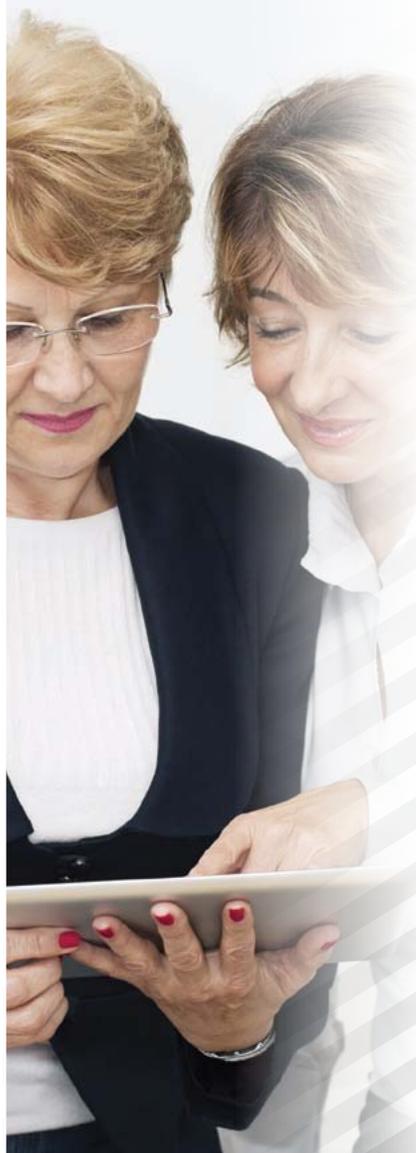
1. Be eligible for the Nebraska Medical Assistance Program (NMAP/Medicaid);
2. Have participated in an assessment with a Services Coordinator;
3. Have care needs, which would otherwise require services to be provided in a Nursing Facility (NF). Medicaid criteria for admission to a nursing facility is found in Title 477, Chapter 2 of the Nebraska Administrative Code (477 NAC 2-001)
4. Have received an explanation of NF and waiver services and elected to receive waiver services; and
5. Work with the Services Coordinator to develop an individualized, outcome-based, cost-effective service plan.

Services Coordinators collect information on each individual seeking waiver services to determine the functional abilities and care needs of that individual.

- ➔ Information may be gathered from a variety of sources (e.g., the individual, family, care providers, physicians, facility staff, case files, medical charts) using observation, documentation review and/or interviews until sufficient information is obtained to determine the individual's current functioning in each area.
- ➔ Individuals who require assistance, supervision, or care in at least one of the following four categories meet the level of care criteria for Nursing Facility or Aged and Disabled Home and Community-Based Medicaid Waiver services:
 1. Limitations in three or more Activities of Daily Living AND medical treatment or observation;

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2. Limitations in three or more Activities of Daily Living AND one or more Risk factor;
 3. Limitations in three or more Activities of Daily Living AND one or more Cognition factor; OR
 4. Limitations in one or more Activities of Daily Living AND one or more Cognition factor AND one or more Risk factor.
- ➔ For those individuals that meet NF level of care, the Services Coordinator shall then determine if the individual meets priority criteria.

If the potential individual does not meet the NF level of care criteria, the Services Coordinator shall inform the referral source of this decision and provide notice to the potential individual/authorized representative. The Services Coordinator shall also provide appropriate information and referral. Notices to individuals must contain:

1. A clear statement of the action to be taken;
2. A clear statement of the reason for the action;
3. A specific policy reference which supports such action; and
4. A complete statement of the individual's right to appeal.



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Overview of Payment Structure

Payment for Medicaid Waiver Assisted Living, as it applies to the DHHS Home and Community-Based Services Medicaid Waiver for Aged Persons and Adults with Disabilities, consists of **two main components**. The first is Room and Board and the second is Medicaid Waiver Assisted Living Services.

Medicaid Waiver Assisted Living Rates, also referred to as "Per Day Equivalents," are calculated to cover the total of all Medicaid Waiver Assisted Living costs/payments. Rates are applied as "Standard," "Urban vs. Rural" and "Single vs. Multiple Occupancy." Current rates are available on the Nebraska Department of Health & Human Services website and by subscribing to the "**Provider Bulletins**" page at <http://goo.gl/l2e5iN>.

Only the Services portion billed are paid under the DHHS Home and Community-Based Services Medicaid Waiver for Aged Persons and Adults with Disabilities.

Payment for Room and Board

Medicaid does not pay for **Room and Board**. Each resident is financially responsible for his/her Room and Board and should be contacted directly for payment. Individuals may pay Room and Board with funds they receive from any of several sources such as Social Security benefits, Supplemental Security Income (SSI), a retirement/pension or a DHHS grant (Aid to the Aged, Blind and Disabled/AABD or State Supplemental).

Prorate each individual's payment for Room and Board in the month they are initially authorized for Medicaid Waiver Assisted Living by dividing the Room and Board amount by the number of days in the applicable month and multiplying that by the number of days the individual is an authorized Medicaid Waiver individual of the assisted living.

Prorating the Room and Board amount also applies for months when the individuals are discharged.

The Room and Board portion may be collected at the beginning, ending or during each month or according to whatever agreement is reached between the individual, his/her family and the assisted living.

Payment for Medicaid Waiver Assisted Living Services

The balance of the monthly Medicaid Waiver Assisted Living amount is for Waiver Services. The Services portion (Level of Care amount minus the Room and Board) is used to calculate the Per Day Equivalent for each Level of Care.

Payment to the assisted living for the Medicaid Waiver Services portion must be **prior authorized** by the Services Coordinator. Waiver providers will receive a Medicaid payment directly from DHHS. In addition to Room and Board, the individual may have funds he/she must obligate before DHHS will assume financial responsibility for the Services component.

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Each individual may have a monthly “spend down” obligation. This “spend down” or “Share of Cost” is called the Paid from Other Sources (POS) Amount and will be received by your assisted living near the end of each month. Please work closely with the individual, his/her family and local DHHS Medicaid Social Service Worker to arrange for collection of the POS Amount.

Current billing procedures must be followed as described on the **May 24, 2004 H C B S Assisted Living Provider Memorandum:**

- ➔ Monthly Rates will be paid to the assisted living for all on-going months of service when an individual is physically present during the month in the assisted living. The assisted living must notify the Services Coordinator by the next DHHS working day of a medical absence in which an individual is admitted to a hospital or nursing facility. This is required in order for the Services Coordinator and Central office to determine continued appropriateness of the assisted living authorization. Failure to report medical absences to the Services Coordinator may result in the assisted living being required to reimburse DHHS for days the client was out for medical reasons.
- ➔ For the months of admission and discharge, “Service Begin/Service End”, the assisted living is paid a daily rate for all days in which the individual is physically present after authorization or prior discharge. For days during the month following the date of admission or the last month prior to the date of discharge when the client is out of the assisted living for any reason, the assisted living will receive 90% of the daily rate as a “fixed cost allowance”
 - ➔ Examples:
 - ➔ **“Service Begin” Month:** Individual is authorized for Assisted Living Waiver on the 16th day of the month and individual is physically present each day through the last calendar day of the month. The assisted living is paid the contracted daily rate for 16 days (31- day month).
 - ➔ **“Service Begin” Month:** Individual is authorized for Assisted Living Waiver on the 16th day of the month and the assisted living reports that client is admitted to the hospital (or out on a social visit) on the 21st day of the month and returns on the 24th.
 - ➔ Day 1 through 15 no payment to the assisted living
 - ➔ Day 16 through 21 the facility is paid the contracted daily rate.
 - ➔ Days 22 & 23 are paid the 90% daily rate “fixed cost allowance”.
 - ➔ Day 24 through the last calendar day the assisted living is paid the contracted daily rate.

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- ➔ **“Service End” Month:** Individual is physically present in the assisted living through the day of discharge on the 16th day of the month.
 - ➔ Days 1-16 the assisted living is paid the contracted daily rate.
 - ➔ No payment following Day 16.
 - ➔ “Service End” Month- Individual is physically present in the assisted living on days 1-12. The individual is hospitalized on day 12 and discharged from the assisted living on the 16th day of the month.
 - ➔ Days 1-12 the assisted living is paid contracted daily rate.
 - ➔ Days 13-15 the assisted living is paid 90% daily rate “fixed cost allowance”.
 - ➔ Day 16 (day of discharge) the assisted living is paid the contracted daily rate.
 - ➔ No payment following Day 16.
- ➔ **Day of Discharge:** Providers will be paid for the day of discharge.

Additional information:

- ➔ If there are any questions regarding a bill you can contact the **Nebraska Medicaid Provider Inquiry Line** toll free at **1-877-255-3092**. If calling from Lincoln, dial 471-9128. You will then receive several prompts in order to reach a DHHS Nursing Home/Assisted Living representative. The Medicaid Provider Inquiry Line is available Monday, Wednesday, and Friday, 9:00 AM to noon and 1:00 PM to 4:00 PM (Central Time).
- ➔ When calling the **Nebraska Medicaid Provider Inquiry Line**, please have the individual's Medicaid number and the billing month you have questions on.
- ➔ To enroll in electronic claims call **Nebraska Medicaid Program Electronic Data Interchange (EDI)** help desk at 1-866-498-4357.



SECTION 6

Billing DHHS for Payment

Review the following instructions carefully. Knowing how to properly bill will save you time and energy.

Bills may be submitted either electronically or paper. To enroll in electronic claims call EDI help desk at 1-866-498-4357. Paper claims will be submitted using a UB-04 form. This form can only be mailed or submitted electronically. DHHS does not accept faxed or emailed claims. If your assisted living chooses to mail the claims, send them to:

DHHS Medicaid Claims
PO Box 95026
Lincoln, NE 68509-5026

Instructions on how to file a paper claim is on the DHHS Website at <https://goo.gl/SfNNXI>.

These instructions can be used in combination with the CMS-1450 (UB-04) claim form instructions in the National Uniform Billing Committee Data Specifications Manual's CMS-1450 (UB-04) claim form instructions. This Data Specifications Manual is available from the National Uniform Billing Committee at: <http://www.nubc.org>.

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1	Provider Name, Address & Telephone Number	Required
2	Pay-to Name and Address	Situational
3a	Patient Control Number -	Situational
	The patient control number will be included on the Medicaid Remittance Advice.	
3b	Medical/Health Record Number	Situational
	The number assigned to the patient's medical/health record by the provider	
4	Type of Bill	Required
	Use Bill Type code 66X for assisted living Waiver services	
	Third digit (X) must correspond to claim frequency code:	
	1 = Admit through Discharge Claim	
	2 = Interim - First Claim	
	3 = Interim - Continuing Claim	
	4 = Interim - Last Claim	
5	Federal Tax Number	Required
6	Statement Covers Period	Required
	Enter beginning and end claim services dates	
7	Reserved for Assignment by the NUBC	Not Used
8	Patient Name/Identifier	Required
	The patient is the person who received services	

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9	Patient Address	Required
	The patient address will be the facility address	
10	Patient Birth Date	Required
11	Patient Sex	Required
12	Admission Date	Required
	The date the resident was admitted to the assisted living	
13	Admission Hour	Not Used
14	Priority (Type of Visit)	Not Used
15	Source of Referral for Admission	Not Used
16	Discharge Hour	Not Used
17	Patient Discharge Status	Situational
	Code indicates the disposition or discharge status of the individual for the period covered by the claim and is required only when the individual's stay ends at the assisted living.	
18-28	Condition Codes	Not Used
29	Accident State	Not Used
30	Reserved for National Assignment by the NUBC	Not Used
31-34	Occurrence Codes and Dates	Not Used
35-36	Occurrence Span Code and Dates	Situational
	Use Occurrence Span Code 74 to report Hospital Days and enter the beginning and end dates	
37	Reserved for National Assignment by the NUBC	Not Used
38	Responsible Party Name and Address	Not Used
39-41	Value Codes and Amounts	Not Used
42	Revenue Code	Required
	*Use Revenue Codes 0100 through 0179 to report In-Facility Days	
	*Use Revenue Codes 0183 to report Therapeutic Leave Days	
	*Use Revenue Codes 0185 to report Hospital Leave Days	
	*Use revenue Codes 0180 to report Non-Billable Leave Days	
	*Do NOT report Leave Days on Swing Bed Claims	
43	Revenue Description	Situational
	For Assisted Living, the following descriptions may be used as appropriate	
	*Days in AL	
	*Hospital Leave Days	
	*Therapeutic Leave Days	
44	Rates	Required
	Enter provider's usual and customary rate	
45	Service Date	Not Used
46	Units of Service	Required
	Enter the number of days corresponding to the Revenue Code(s) reported in 42. Days must be entered as whole numbers, not decimals or fractions.	

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FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
47	Total Charges (by Revenue Code Category) Multiply the number of days reported in 46 by the rate reported in 44.	Required
48	Non-Covered Charges	Not Used
49	Reserved for National Assignment by the NUBC	Not Used
50	Payer Name Use when another payer was primary to Medicaid or the client had a share of cost.	Situational
51	Health Plan Identification Number Use when another payer was primary to Medicaid or the client had a share of cost.	Situational
52	Release of Information certification Indicator	Not Used
53	Assignment of Benefits Certification Indicator	Not Used
54	Prior Payments-Prayers *For services listed on this claim, enter any payments made, due, or obligated for other sources unless the source is Medicare. Other sources may include health insurance, liability insurance, excess income, etc. *A copy of the Medicare Explanation of Benefits (EOB), insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms. *DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (Provider "write-off" amount). *Enter Patient's share of cost amount (POS), if paid	Situational
55	Estimated Amount Due-Payer	Not Used
56	National Provider Identifier- Billing Provider Enter the National Provider Identifier (NPI) of the Billing Provide, as reported to Nebraska Medicaid	Required
57	Other Provider Identifier Enter the eleven-digit Nebraska Medicaid provider number assigned by Nebraska Medicaid (example: 123456789- 12). All payments will be made to the provider name and address listed on the Medicaid provider agreement associated with this provider number.	Required
58	Insured's Name Enter Medicaid recipient's name	Required
59	Patient's Relationship to Insured Use Patient Relationship code 18 for all claims	Required
60	Insured's Unique Identification Enter the Medicaid recipient's complete eleven-digit identification number (example: 123456789-01)	Required
61	(Insured) Group Name Recommended when Nebraska Medicaid is the secondary payer	Situational
62	Insurance Group Number Recommended when Nebraska Medicaid is the secondary payer	Situational

SECTION 6

Department of Health & Human Services

DHHS
NEBRASKA

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
63	Treatment Authorization Code	Situational
64	Document Control Number (DCN)	Situational
	Required when Type of Bill Frequency Code (FL04) indicates this claim is a replacement claim or void to a previously adjudicated claim.	
65	Employer Name of the Insured	Not Used
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	Required
	The qualifier denotes the version of International Classification of Diseases reported.	
	The ICD Version Indicator will be used to distinguish if the submitted Code is an ICD-9 or an ICD-10 Code	
	Version '9' indicates the Codes entered as ICD-9 Diagnosis or Surgical Procedure Code	
	Version '0' indicates the Codes entered as ICD-10 Diagnosis or Surgical Procedure Code	
67	Principal Diagnosis Code	Required
	Enter the International Classification of Diseases - Clinical Modification (ICD-CM) code describing the principal/primary diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care)	
	*The COMPLETE diagnosis code is required, as defined in ICD-CM	
	*NOTE: For Assisted Livings only, enter ICD-9-CM, V719 and for ICD-10, Z049	
67-A-Q	Other Diagnosis Codes - ICD-CM	Situational
	Enter the ICD-CM codes corresponding to conditions that co-exist at the time of admission, or that develop subsequently, and that affect the treatment received and/or the length of stay.	
68	Reserved for National Assignment by the NUBC	Not Used
69	Admitting Diagnosis	Not Used
70 a-c	Patient's Reason for Visit	Not Used
71	Prospective Payment System (PPS) Code	Not Used
72	ICD-9 External Cause of Injury (ECI) Code	Not Used
	ICD-10 External Cause of Morbidity (V, W, X, or Y Codes)	Not Used
73	Reserved for National Assignment by the NUBC	Not Used
74	Principal Procedure Code and Dates N	Not Used
74 a-e	Other Procedure Codes and Dates N	Not Used
75	Reserved for National Assignment by the NUBC	Not Used
76	Attending Provider Name and Identifiers	Required
	Enter the practitioner's license number. The practitioner license number must begin with the two-digit state abbreviation followed by the state license number (example: NE123456). Enter the attending practitioner's last and first name.	
	*NOTE: For Assisted Living providers, this field is no longer required.	
77	Operating Physician Name and Identifiers	Not Used
78-79	Other Provider Name and Identifiers	Not Used

SECTION 6

Department of Health & Human Services

DHHS
N E B R A S K A

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
80	Remarks Field	Situational
	Use the explain unusual services and to document medical necessity, for example, when unit limitations are exceeded.	
81	Code-Code Field	Situational
	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	
81cc.a	TAXONOMY CODE OF THE BILLING PROVIDER	
	Enter the 10-digit taxonomy code of the Billing Provider, as reported to Nebraska Medicaid.	
81cc.b	ZIP CODE OF THE BILLING PROVIDER	
	Enter the nine-digit Zip Code (Zip + 4) of the Billing Provider, as reported to Nebraska Medicaid.	

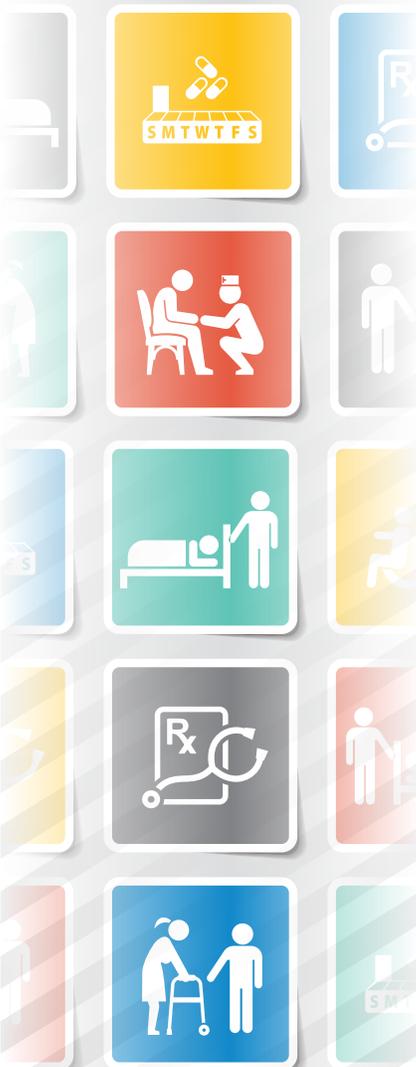


SECTION 7 APPENDICES

Appendices

Page

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Appendix

A

Plan of Services and Supports



Division of Medicaid and Long-Term Care
 Plan of Services and Supports
 Aged and Disabled/Traumatic Brain Injury Medicaid Waivers

Department of Health & Human Services
DHHS
 N E B R A S K A

Client's Name	Client CONNECT ID #	Page 1 of 1
Services Coordinator	POSS Development Date	

Waiver eligibility period covered
 From (date) _____ Through (date) _____

SECTION 1: OUTCOMES

Assessment Section:	Desired Outcome:
---------------------	------------------

SECTION 2: ACTION STEPS

Steps to be taken	By whom	Check box when step is completed
		<input type="checkbox"/>

SECTION 3: SIGNATURES

1. Client's Plan of Services and Supports Review: I acknowledge that I, or my legal representative, have reviewed my Plan of Services and Supports.

Signature of Client/Legal Representative	Date
Signature of Services Coordinator	Date

2. Provider Choice: I have freely chosen the providers of my services for the time period of this plan.

Signature of Client/Legal Representative	Date
--	------

3. Sharing the Plan of Services and Supports: A copy will be sent to your Assisted Living Provider (if applicable) or others at your request. Please list below any others to whom you request copies of your Plan of Services and Supports be distributed.

Name of Person/Agency	Address
Name of Person/Agency	Address

COPIES: Numerous copies may be used to reflect the entire Plan of Services and Supports.
SIGNATURE: Required only on last page.



Appendix

B

Assisted Living Service Provider Agreement



Department of Health & Human Services
 Division of Medicaid and Long-Term Care
Nebraska Service Provider Agreement
 Provider Addendum

Medicaid & Long-Term Care Use Only	
Medicaid ID #	
N-Focus ID #	

Provider Identification

Provider Name	Date of Birth
<input type="text"/>	
Social Security Number	FTIN
<input type="text"/>	

General Provider Requirements

By signing this agreement, the service provider agrees to:

1. Keep current any state or local license/certification required for service provision.
2. Not provide services if s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
3. Not use any federal funds received to influence agency or congressional staff.
4. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect, and/or the sex offender registries and the U.S. Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities.
5. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow the Department staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place.
6. Have the knowledge, experience, and/or skills necessary to perform the task(s).
7. Submit billing documents after service is provided and within six months from date of service.
8. Assume that the rate negotiated or charged does not exceed the amount charged to private payers; bill only for services which are authorized and actually provided.
9. Respect every client's right to confidentiality and safeguard confidential information.
10. Understand and accept responsibility for the client's safety and property.
11. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, changes in client function).
12. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate Department staff.

Service Provision

Service Code	Service	Maximum Rate	Frequency

The party requesting a change in the above terms must notify the other party at least thirty (30) days before the date the proposed change is to be implemented, except for rate changes due to minimum wage changes, rates regulated by governmental agencies, or other changes required by law.

Attach documentation of basic or specialized status of Medicaid Personal Assistance Service Provider.

Comments

Signatures and Dates

I certify that I have read and understand the standards as stated and referenced above and agree to comply with all the terms of this Agreement.

Provider/Agency Representative Signature _____ Date _____

Parent or Legal Guardian Signature (If required) _____ Date _____

Signature of Authorized Representative - Nebraska Department of Health and Human Services _____ Date _____



MC-190 (09023) Revised 8/13



Appendix

C

Provider Release of Information Felony/Misdemeanor Statement



Division of Medicaid and Long-Term Care
Provider Release of Information
Felony/Misdemeanor Statement

Department of Health & Human Services



Section I

I understand that the Nebraska Department of Health and Human Services requires the following background information on me. History may be requested from law enforcement or criminal justice agencies, including but not limited to:

- State of Nebraska Adult/ Child Abuse and Neglect Central Registry/er
- Law Enforcement Records
- The State of Nebraska Sex Offender's Registry
- The Nebraska Department of Motor Vehicles Nebraska Driver License Information System
- License Information System
- GSA website <http://epls.gov> for debarment actions by federal agencies and exclusion actions from Medicare, Medicaid or other federal programs through the Office of Inspector General at www.oig.hhs.gov/fraud/exclusions.asp

- I am applying to provide services OUTSIDE OF THE CLIENT'S HOME. Location: _____
If you will be providing services in your home or someone else's home, the Department requires background information on all members of that household including full names, previous names, birthdates and Social Security numbers on all persons living in that residence and any criminal background information. I understand this information is required in determining my approval as a service provider. **Complete page 3 if needed.**
- I am applying to provide services IN THE HOME OF A CLIENT.
No other persons will be involved in the provision of these services. Therefore, no other persons will need to be cleared with the Department in determining my approval as a service provider
- Assisted Living Employee: DHHS shall review employer policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse/neglect are in place. In addition, employees will complete this form.

Name of Facility	City
Position	Date of Hire

Section II

NAME (Print):

First	Middle	Last
-------	--------	------

PREVIOUS NAMES:

(List All Previous Married, Maiden or Other Legal Names or Write NONE)

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ GENDER: _____

CURRENT ADDRESS:

List each residence in the last 10 years (Add rows as needed)

COUNTY	CITY	STATE	DATE
_____	_____	_____	_____
_____	_____	_____	_____

Add Row



Appendix

C

Provider Release of Information Felony/Misdemeanor Statement

Department of Health & Human Services



Section III

My Record of Felonies / Misdemeanors / Arrests and / or Convictions and any pending charges is as follows:

(List details including dates and disposition, i.e., Parole, Probation, Fine, Time Served, etc. OR "NONE") (Add rows as needed)

Offense	Date	City	State	Outcome

Add Row

Section IV

NAMES AND BIRTHDATES OF CHILDREN THROUGH AGE 12 LIVING IN MY HOME:

Name	Date of Birth	Name	Date of Birth

Section V

I understand that Law Enforcement records may be obtained and reviewed at any time to determine the above statements. Any false statements may result in termination or denial of any independent contractors.

Signature _____

Date _____

Parent/Guardian Signature (Required if individual is under the age of 19 and not married) _____

Date _____

Instructions for Completing Form MC-199

PROVIDER RELEASE OF INFORMATION/FELONY MISDEMEANOR STATEMENT

Form MC-199 is used to obtain information to complete background checks which are required for approval as a provider. This form is used to allow potential and renewing providers and/or their employees to self-disclose any current charges, pending indictments or any convictions they have had. Individual providers must complete the form every 12 months before their provider service agreement may be signed or renewed. For providers who provide the service in their home, each household member must also complete the form at the same time. Assisted Living providers must have each employee complete this form annually.

COMPLETION:

Section I: Check the appropriate boxes to indicate why the form is being completed and the type of individual completing the form. If the provider is an assisted living facility, enter the name and city of the facility, the position and date of hire of the individual employee who is completing the form.

Section II: Enter individual's name, other names used (including other married names, aliases, etc.), Social Security Number, date of birth and all addresses where he/she has previously resided.

Section III: List any record of current charge(s), pending indictment(s), or conviction(s) regarding misdemeanor or felony actions. This must include details, dates and disposition (e.g., parole, probation, incarceration, fine, community service, etc.). If person has no felonies or misdemeanors, write "none" in the "Offense" column.

Section IV: List all children through age 12 living in the home.

Section V: The form must be signed and dated by the individual. The parent/guardian must also sign and date the form if the individual is under 19, not emancipated, or if he/she has a legal guardian.

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Previously MILTC-1500



Appendix

C

Provider Release of Information Felony/Misdemeanor Statement

Department of Health & Human Services



Statement of Background Information for Other Household Members and/or Staff Age 13 and Over

1.

(Print) First, Middle, and Last name	Date of Birth	Social Security #
Household Status, i.e. Husband, Son, etc.	Sex	Previous Last Names
County/City/State and DATE of each residence in the last 10 years		
Add Row		
Criminal History/Record (List Date and Dispositions or write "NONE")		
Add Row		
Signature		

2.

(Print) First, Middle, and Last name	Date of Birth	Social Security #
Household Status, i.e. Husband, Son, etc.	Sex	Previous Last Names
County/City/State and DATE of each residence in the last 10 years		
Add Row		
Criminal History/Record (List Date and Dispositions or write "NONE")		
Add Row		
Signature		

3.

(Print) First, Middle, and Last name	Date of Birth	Social Security #
Household Status, i.e. Husband, Son, etc.	Sex	Previous Last Names
County/City/State and DATE of each residence in the last 10 years		
Add Row		
Criminal History/Record (List Date and Dispositions or write "NONE")		
Add Row		
Signature		

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Previously MILTC-1500



Appendix

D

Client Consent for Multiple Occupancy



Nebraska Department of Health and Human Services
Home and Community-Based Waiver for Aged Persons and Adults with Disabilities
Assisted Living Service
Client Request for Multiple Occupancy

Section 1

Client Name _____ Social Security Number _____

Section 2

Provider Name _____ City _____

Section 3

I desire to share an assisted living apartment with:

Name	Relationship
_____	_____

I understand this is a voluntary choice. I may request to change this living arrangement at any time and will notify the facility administrator and my Waiver Services Coordinator of this decision.

Section 4

Multiple occupancy rates are computed at 80% of the single occupancy rate. Multiple occupancy requires prior approval of HHS and request form signed by the client, roommate, facility representative and Services Coordinator.

I have read and understand the request as stated above and agree to comply with the terms.

Client/Guardian _____ Date _____

Roommate/Guardian _____ Date _____

Facility Representative _____ Date _____

Services Coordinator _____ Date _____

WHITE- Client; YELLOW- Local Office; PINK- Provider

MILTC-21 10/14 (57091)



Appendix

E

Sample UB04 Billing Form

Department of Health & Human Services



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Appendix

F

REGULATIONS TITLE 471 CHAPTER 1

Title 471 Chapter 1

CHAPTER 1-000 ADMINISTRATION

1-001 Introduction: This title addresses services provided under the Nebraska Medical Assistance Program (also known as Nebraska Medicaid).

1-001.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) was established under Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Neb.Rev.Stat. §68-1018. NMAP is administered statewide by the Nebraska Department of Health and Human Services Finance and Support (HHS Finance and Support or the Department).

1-001.02 Purpose: The Nebraska Medical Assistance Program was established to provide medical and other health-related services to aged, blind, or disabled persons; dependent children; and any persons otherwise eligible who do not have sufficient income and resources to meet their medical needs.

1-001.03 Title XIX Plan: The State Plan for Title XIX of the Social Security Act - Medical Assistance Program is a comprehensive written commitment of the state to administer the Nebraska Medical Assistance Program in accordance with federal requirements. The Title XIX Plan is approved by the Federal Department of Health and Human Services. The approved plan is a basis for determining federal financial participation in the state program. The rules and regulations of NMAP implement the provisions of the Title XIX Plan.

1-002 Nebraska Medicaid-Coverable Services: The Nebraska Medical Assistance Program covers the following types of service, when medically necessary and appropriate, under the program guidelines and limitations for each service:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Rural health clinic services;
4. Federally qualified health center services;
5. Laboratory and x-ray services;
6. Nurse practitioner services;
7. Nursing facility (NF) services;
8. Home health services;
9. Early and periodic screening, diagnosis, and treatment (HEALTH CHECK);
10. Family planning services;
11. Physician services and medical and surgical services of a dentist;
12. Nurse midwife services;

Appendix

F

REGULATIONS TITLE 471 CHAPTER 1

Department of Health & Human Services

DHHS
NEBRASKA

13. Prescribed drugs;
14. Services in intermediate care facilities for the mentally retarded (ICF/MR);
15. Inpatient psychiatric services for individuals under age 21;
16. Inpatient psychiatric services for individuals age 65 and older in an institution for mental diseases;
17. Personal assistance services;
18. Clinic services;
19. Psychologist services;
20. Dental services and dentures;
21. Physical therapy services;
22. Speech pathology and audiology services;
23. Medical supplies and equipment;
24. Prosthetic and orthotic devices;
25. Optometric services;
26. Eyeglasses;
27. Private duty nursing services;
28. Podiatry services;
29. Chiropractic services;
30. Case management services;
31. Medical transportation, including ambulance services;
32. Occupational therapy services;
33. Emergency hospital services;
34. Screening services (mammograms); and
35. Home and community-based waiver services (see Title 480 NAC).

(Certain services covered under the home and community-based waivers may not meet the general definition of "medical necessity" and are covered under the NMAP.)

1-002.01 Nebraska Medicaid Managed Care Program: Certain Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program also known as the Nebraska Health Connection (NHC). The Department developed NHC to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State. Enrollment in NHC is mandatory for certain clients in designated geographic areas of the state. The client's participation in NHC will be indicated on the client's NHC ID Document. NHC clients will receive a Nebraska Medicaid Identification Card.

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Participation in NHC can be verified by accessing the Department Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580) (see 471-000-124); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or using the standard electronic Health Care Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transaction Instructions at 471-000-50).

NHC utilizes two models of managed care plans to provide the basic benefits (medical/surgical) package; these models are health maintenance organizations (HMO's) and primary care case management (PCCM) networks. NHC also provides a mental health and substance abuse services (MH/SA) benefits package that is available statewide to all clients who are required to participate in NHC. See 471-000-122 for a list of NHC's plans.

Services included in the benefits package that are provided to a client who is participating in NHC must be coordinated with the plan. The requirements for provision of services in the NHC benefits package are included in the appropriate Chapters of this Title. Services that are not included in the benefits package will be subject to all requirements of this Title.

For clients enrolled in an NHC plan for the basic benefits package, co-payments are required only for prescription drugs. Clients enrolled only in the NHC mental health/substance abuse plan are subject to co-payments required under 471 NAC 3-008 ff.

1-002.02 Limitations and Requirements for Certain Services

1-002.02A Medical Necessity: NMAP applies the following definition of medical necessity:

Health care services and supplies which are medically appropriate and –

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

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

Approval by the federal Food and Drug Administration (FDA) or similar approval does not guarantee coverage by NMAP. Licensure/certification of a particular provider type does not guarantee NMAP coverage.

1-002.02B Place of Service: Covered services must be provided at the least expensive appropriate place of service. Payment for services provided at alternate places of service may be reduced to the amount payable at the least expensive appropriate place of service, or denied, as determined by the appropriate staff of the Medicaid Division.

1-002.02C Experimental or Investigational Services: NMAP does not cover medical services which are considered investigational and/or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, NMAP prohibits payment for these services.

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

1-002.02C1 Related Services: NMAP does not pay for associated or adjunctive services that are directly related to non-covered experimental/investigational services (for example, laboratory services, radiological services, other diagnostic or treatment services, practitioner services, hospital services, etc.).

NMAP may cover complications of non-covered services once the non-covered service is completed (see 471 NAC 1-002.02L).

1-002.02C2 Requests for NMAP Coverage: Requests for NMAP coverage for new services or those which may be considered experimental or investigational must be submitted before providing the services, or in the case of true medical emergencies, before submitting a claim. Requests for NMAP determinations for such coverage must be submitted in writing to the NMAP Medical Director at the following address by mail or fax method:

Medical Director

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

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

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

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

1-002.02C3 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.

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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.

1-002.02D Cosmetic and Reconstructive Surgery: NMAP limits reimbursement for cosmetic and reconstructive surgical procedures and medical services that are performed when medically necessary for the purpose of correcting the following conditions:

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

1-002.02D1 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:

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

1-002.02D2 Cosmetic and Reconstructive Prior Authorization Procedures:

In addition to the prior authorization requirements under 471 NAC 18-004.01, the surgeon who will be performing the cosmetic or reconstructive (C/R) surgery shall submit a request to the Medical Director. This request must include the following:

1. An overview of the medical condition and medical history of any conditions caused or aggravated by the condition;
2. Photographs of the involved area(s) when appropriate to the request;
3. A description of the procedure being requested including any plan to perform the procedure when it requires a staged process; and
4. When appropriate, additional information regarding the medical history may be submitted by the client's primary care physician.



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Prior authorization request for cosmetic and reconstructive surgery must be submitted using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or in writing by mail or fax to the following address:

Medical Director

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

1-002.02E Preventive Health Care: To ensure early detection and treatment, to maintain good health, and to ensure normal development, NMAP provides the HEALTH CHECK program to clients age 20 and younger. HEALTH CHECK is a program of early and periodic screening, diagnosis, and treatment (EPSDT) designed to combine the health services of screening, diagnosis, and treatment with outreach, supportive services, and follow-up to promote and provide preventive health care. See 471 NAC 33-000.

Other preventive health care services covered by NMAP are listed in the individual provider chapters.

1-002.02F Family Planning Services: NMAP covers family planning services, including consultation and procedures, when requested by the client. Family planning services and information must be provided to clients without regard to age, sex, or marital status, and must include medical, social, and educational services. The client must be allowed to exercise freedom of choice in choosing a method of family planning. Family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician or registered nurse.

Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

1-002.02G Services Provided Outside Nebraska: Payment may be approved for services provided outside Nebraska in the following situations:

1. When an emergency arises from accident or sudden illness while a client is visiting in another state and the client's health would be endangered if medical care is postponed until she/he returned to Nebraska;
2. When a client customarily obtains a medically necessary service in another state because the service is more accessible;

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3. When the client requires a medically necessary service that is not available in Nebraska; and
4. When the client requires a medically necessary nursing facility (see 471 NAC 12-014.04) or ICF/MR (see 471 NAC 31-003.05) service not available in Nebraska.

1-002.02G1 Prior Authorization Requirements: Prior authorization is required for services provided outside Nebraska when –

1. The service is not available in Nebraska (see 471 NAC 1-002.02G, items 3 and 4); or
2. The service requires prior authorization under the individual chapters of this Title.

1-002.02G2 Prior Authorization Procedures for Out-of-State Services: The referring physician shall submit a request to the Department using the standard electronic Health Care Services Review Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or by mail or fax to the following address:

Medical Director

Nebraska Department of
Health and Human Services Finance and Support
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026
Fax telephone number: (402) 471-9092

For prior authorization procedure for nursing facility services, see 471 NAC 12-014.04. For prior authorization procedures for ICF/MR services, see 471 NAC 31-000.

The request must include the following information or explanation as appropriate to the case:

1. A summary of the client's physician's evaluation of the client and the determination that the service is not available in Nebraska, or if available, the service is not adequate to meet the client's needs;
2. The name, address, and telephone number of the out-of-state provider;
3. An indication of whether the out-of-state provider is enrolled or is willing to enroll as a Nebraska Medicaid provider and accept the Medicaid allowable payment as payment in full for the services;
4. A description of the client's condition. The physician must certify, based on a thorough evaluation, that the services being requested are medically necessary and not experimental or investigational;

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5. Identification of the physician who will be assuming follow-up care when the client returns to Nebraska;
6. Any plan for follow-up and return visits, including a timeline for the visits (for example, annually, every six months, as needed), and an explanation of the medically necessity for the return visits;
7. If the client is requesting assistance with transportation, the type of transportation appropriate for the client's condition, and when ambulance, air ambulance, or commercial air transportation is being requested, the request must provide an explanation of medical necessity; and
8. The client's name, address, and Medicaid recipient identification number, or date of birth.

1-002.02H Sales Tax: The State of Nebraska is tax-exempt; therefore, providers shall not charge sales tax on claims to the Department or Medicaid. Sales tax may be an appropriate inclusion on cost reports.

1-002.02J Services Not Directly Provided For Treatment or Diagnosis:

Medicaid does not cover services provided to a client that are not directly related to diagnosis or treatment of the client's condition (for example, blood drawn from a client to perform chromosome studies because a relative has had problem pregnancies, paternity testing, research studies, etc.). Exception: For transplant-donor-related services, see 471 NAC 10-005.20 and 18-004.40.

1-002.02J1 Autopsies: Medicaid does not pay for autopsies.

1-002.02K (Reserved)

1-002.02L Services Required to Treat Complications or Conditions Resulting from Non-Covered Services:

Medicaid may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

Medical inpatient or outpatient hospital services are sometimes required to treat a condition that arises from services which Medicaid does not cover. Payment may be made for services furnished under these circumstances if they are reasonable and necessary and meet Medicaid requirements in 471 NAC.

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

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

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

1-002.02M Drug Rebates

1-002.02M1 Legal Basis: These regulations govern the Drug Rebate Program, established by Section 1927 of the Social Security Act, attached and incorporated by reference. The definitions and terms in Section 1927 of the Social Security Act apply to these regulations.

The Nebraska Medical Assistance Program, also known as Nebraska Medicaid, covers prescribed drugs only if the labeler has signed a Rebate Participation Agreement with the Secretary of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Coverage of prescribed drugs is subject to 471 NAC 16-000, Pharmacy Services.

1-002.02M2 Rebate Dispute Resolution: If, in any quarter, a manufacturer discovers a discrepancy in Medicaid utilization information that the manufacturer and the Department are unable to resolve in good faith, the manufacturer must provide written notice of the discrepancy by National Drug Code (NDC) number to the Department within 30 days after receiving the Medicaid utilization information.

If the manufacturer, in good faith, believes that the Medicaid utilization information is erroneous, the manufacturer must pay the Department that portion of the rebate amount claimed that is not disputed within 30 days after receiving the Medicaid utilization information. The balance due, if any, plus a reasonable rate of interest as set forth in Section 1903(d)(5) of the Social Security Act must be paid or credited by the manufacturer or by the Department by the due date of the next quarterly payment after resolution of the dispute.

The Department and the manufacturer must use their best efforts to resolve the discrepancy within 60 days of receipt of notification. If the Department and the manufacturer are not able to resolve a discrepancy within 60 days, CMS requires the Department to make available to the manufacturer the Department's administrative hearing process under 465 NAC 6.

The hearing decision is not binding on the Secretary of Health and Human Services, CMS, for purposes of his/her authority to implement a civil money penalty provision of the statute or the rebate agreement.



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Nothing in this section precludes the right of the manufacturer to audit the Medicaid utilization information reported or required to be reported by the Department.

Adjustments to rebate payments must be made if information indicates that either Medicaid utilization information, average manufacturer price (AMP), or best price is greater or less than the amount previously specified.

1-002.02M3 Manufacturer Right to Appeal: Every manufacturer of a rebatable drug that has a signed rebate agreement has the limited right to appeal to the Director of Finance and Support for a hearing. This appeal right is limited to any discrepancies in the quarterly Medicaid utilization information only. No other matter relating to that manufacturer's drugs may be appealed to the Director, including but not limited to the drug's coverage status, prior authorization status, estimated acquisition cost, state maximum allowable cost, or allowable quantity.

A manufacturer must request a hearing within 90 days of the date the Department gives notice to the manufacturer of the availability of the hearing process for the disputed drugs.

1-002.02M4 Filing a Request: If the manufacturer wishes to appeal an action of the Department, the manufacturer must submit a written request for a hearing to the Director of Finance and Support. The manufacturer must identify the basis of the appeal in the request.

1-002.02M5 Scheduling a Hearing: When the Director receives a request for hearing, the request is acknowledged by a letter which states the time and date of the hearing.

1-002.02M6 Hearings: Hearings are scheduled and conducted according to 465 NAC 6-000, Practice and Procedure for Hearings in Contested Cases Before the Department.

1-002.02M7 Supplemental Drug Rebates: In addition to the requirements for drug rebates as described and defined in 471 NAC 1-002.02M Drug Rebates, the NMAP may negotiate and contract for supplemental rebates with labelers of prescribed drugs. The negotiations and contracts may be between the labeler and the Department or an entity under contract with the Department to negotiate these supplemental rebates, including a single or multi-state drug purchasing pool. Any entity under contract with the Department shall be fee based, and there will be no financial incentives or bonuses based on inclusion or exclusion of medications from the Preferred Drug List.

Only those drugs meeting the requirements under 471 NAC 1-002.01 and which are otherwise eligible for coverage by NMAP are eligible for coverage.



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Supplemental drug rebate agreements between the Department and/or the entity under contract to negotiate these agreements will be required as described under the provisions of 471 NAC 16-004.03 Preferred Drug List and Pharmaceutical and Therapeutics Committee.

1-002.02N Requirements for Written Prescriptions: The Nebraska Medical Assistance Program will not pay for written prescriptions for prescribed drugs unless executed on a tamper-resistant pad as required by federal law. This includes written prescriptions:

1. For otherwise covered prescription-only and over-the-counter drugs.
2. When Medicaid is the primary or secondary payer.
3. For drugs provided in Nursing Facilities, ICF/MR facilities, and other specified institutional and clinical settings (inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis) when the drug is separately reimbursed.

1-002.02N1 Exclusions: The following prescriptions and other items are not required to be written on tamper-resistant prescription pads:

1. Orders for drugs provided in Nursing Facilities, ICF/MR facilities, and other specified institutional and clinical settings (inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis) for which the drug is not separately reimbursed, but is reimbursed as part of a total service;
2. Refills of written prescriptions that are presented at a pharmacy before April 1, 2008;
3. Faxed prescriptions;
4. Telephoned, or otherwise orally transmitted prescriptions;
5. E-prescribing, when the prescription is transmitted electronically;
6. Prescriptions for Medicaid recipients that are paid entirely by a managed care entity; and
7. Co-pays covered by DHHS funds for prescriptions for drugs covered by Medicare Part D, for certain dual eligible persons.

1-002.02N2 Effective April 1, 2008, a written Medicaid prescription must contain at least one of the following characteristics:

1. An industry-recognized feature designed to prevent unauthorized copying of a completed or blank prescription form, such as a high security watermark on the reverse side of the blank or thermochromic ink;
2. An industry-recognized feature designed to prevent erasure or modification of information written on the prescription by the prescriber,

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such as tamper-resistant background ink that shows erasures or attempts to change written information; or

3. An industry-recognized feature designed to prevent the use of counterfeit prescription forms, such as sequentially numbered blanks or duplicate or triplicate blanks.

1-002.02N3 Effective October 1, 2008, a written Medicaid prescription must contain all three characteristics listed in 471 NAC 1-002.02N2.

1-002.02N4 Emergency Fills: NMAP will pay for emergency fills for prescriptions written on non-tamper resistant pads only when the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant paper. The pharmacy must document the call on the face of the written prescription.

1-003 Verifying Eligibility for Medical Assistance: Providers may verify the eligibility of a client by viewing the client's current Medicaid eligibility document (see 471-000-123 for examples). Clients participating in the Nebraska Medicaid Managed Care Program will have an NHC Identification Document (see 471-000-122). Eligibility may also be verified by contacting the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124) or the client's local HHS office (see 471-000-125), or by using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transaction Instructions at 471-000-50).

When a client initially becomes eligible for medical assistance, she/he may not possess a Medicaid eligibility document until the following month. The provider shall verify the eligibility of the client(s) by contacting NMES or the local office or by using the standard electronic transaction (ASC X12N 270/271).

1-004 Federal and State Requirements: The Department is required by federal and state law to meet certain provisions in the administration of the Nebraska Medical Assistance Program.

1-004.01 Medical Assistance Advisory Committee: The Director of the Department appoints an advisory committee to advise the Director in the development of health and medical care services policies. Members of the committee include physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; members of consumers' groups, including NMAP clients; and consumer organizations, such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; the Director of Regulation and Licensure and the Director of Health and Human Services. Members are appointed on a rotating basis to provide continuity of membership.

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1-004.02 Free Choice of Providers: An NMAP client may obtain covered services from any provider qualified to perform the services who has been approved to participate in NMAP. The client's freedom of choice does not prevent the Department from –

1. Determining the amount, duration, and scope of services;
2. Setting reasonable and objective standards for provider participation; and
3. Establishing the fees which are paid to providers for covered services.

Clients participating in the Nebraska Medicaid Managed Care Program are required to access services through their primary care physician.

1-004.03 Utilization Review (UR): The Department or its designee perform utilization review activities related to the kind, amount, and frequency of services billed to NMAP to ensure that funds are spent only for medically necessary and appropriate services. The Department or its designee may request information from clients' records as part of the utilization review process. In the absence of specific NMAP state UR regulations, Medicare UR regulations may apply.

1-005 Medicare Benefits (Title XVIII) Buy-In: The Department pays monthly premiums for Part B of Medicare only for clients who –

1. Are 65 years of age or older; or
2. Meet the eligibility requirements of disability in Nebraska's Assistance to the Aged, Blind, or Disabled Program.

See 471 NAC 3-004 for further information on Medicare/Medicaid crossover claims and Medicare managed care plans.

1-006 TELEHEALTH SERVICES FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

1-006.01 Definitions

Child: An individual under 19 years of age.

Comparable Service: A service provided face-to-face.

Distant Site: The distant site is the location of the provider of the telehealth service.

Health Care Practitioner: A health care practitioner who is a Nebraska Medicaid-enrolled provider and who is licensed, registered or certified to practice in this state by the Department of Health and Human Services.

H.320: H.320 means the industry-wide compressed audio video communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audio video transmission with a minimum signal of 384 kbps (kilobits per second) over a dedicated line; this may include a switched connection.



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H.323: H.323 means the industry-wide compressed audio video communication standards from the ITU for real time, two-way interactive audio video transmission with a minimum signal of 384 kbps over an intranet or other controlled environment system and compliant with FIPS 140-2.

Originating Site: The originating site is the location of the client at the time of the telehealth service.

Telehealth Services: Medicaid-covered services delivered by a health care practitioner that utilize an interactive audio and video telecommunications system that permits real-time communication between the health care practitioner at the distant site and the client at the originating site. Telehealth services do not include a telephone conversation, electronic mail message, facsimile transmission between a health care practitioner and a client, a consultation between two health care practitioners and asynchronous "store and forward" technology.

1-006.02 Health care practitioners providing telehealth services must follow all applicable state and federal laws and regulations governing their practice and the services they provide.

1-006.03 Originating Sites: Health care practitioners must assure that the originating sites meet the standards for telehealth services. Originating sites must provide a place where the client's right for confidential and private services is protected. Services provided by means of telecommunications technology, other than telehealth behavioral health services received by a child, are not covered if the child has access to a comparable service within 30 miles of his or her place of residence.

1-006.04 Informed Consent: Before an initial telehealth service, the health care practitioner shall provide the client the following written information which must be acknowledged by the client in writing or via email:

1. Alternative options are available, including in-person services, and these alternatives are specifically listed on the client's informed consent statement;
2. All existing laws and protections for services received in-person also apply to telehealth, including:
 - a. Confidentiality of information;
 - b. Access to medical records; and
 - c. Dissemination of client identifiable information;
3. Whether the telehealth session will be or will not be recorded;
4. The client has a right to be informed of all the parties who will be present at each telehealth session and has the right to exclude anyone from either the originating or the distant site;

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5. For each adult client or for a client who is a child but who is not receiving telehealth behavioral health services, a safety plan must be developed, should it be needed at any time during or after the provision of the telehealth service. This plan shall document the actions the client and the health care practitioner will take in an emergency or urgent situation that arises during or after the telehealth service;
6. For each client who is a child who is receiving telehealth behavioral health services:
 - a. An appropriately trained staff member or employee familiar with the child's treatment plan or familiar with the child shall be immediately available in person to the child receiving a telehealth behavioral service in order to attend to any urgent situation or emergency that may occur during provision of such service. This requirement may be waived by the child's parent or legal guardian. The medical record shall document the waiver.
 - b. In cases in which there is a threat that the child may harm himself or herself or others, before an initial telehealth service the health practitioner shall work with the child and his or her parent or guardian to develop a safety plan. Such plan shall document actions the child, the health care practitioner, and the parent or guardian will take in the event of an emergency or urgent situation occurring during or after the telehealth service. Such plan may include having a staff member or employee familiar with the child's treatment plan immediately available in person to the child if such measures are deemed necessary by the team developing the safety plan;
7. The written consent form shall become a part of the client's medical record and a copy must be provided to the client or the client's authorized representative;
8. If the client is a child or otherwise unable to sign the consent form, the client's legally authorized representative shall provide the consent; and
9. When telehealth services are provided in an emergency situation, the health care practitioner shall obtain a signed consent form within seven days of the provision of the emergency telehealth services.

1-006.05 Telecommunications Technology: Medicaid coverage is available for telehealth services and transmission costs when, at a minimum, the H.320 or H.323 audio video standards are met or exceeded for clarity and quality.

1. The telehealth technology solution in use at both the originating and the distant site must be sufficient to allow the health care practitioner to appropriately complete the service billed to Medicaid. These same

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standards apply to any peripheral diagnostic scope or device used during the telehealth session.

2. Coverage is available for teleradiology services when the services meet the American College of Radiology standards for teleradiology.

1-006.06 Reimbursement of Telehealth Services: Telehealth services are reimbursed by Medicaid at the same rate for the service when it is delivered in person.

1-006.07 Reimbursement of Transmission Costs: Transmission cost rates are set forth in the Medicaid fee schedule and include reimbursement for all two-way, real-time, interactive communications, unless provided by an Internet service provider, between the client and the physician or health care practitioner at the distant site which comply with the federal Health Insurance Portability and Accountability Act of 1996 and rules and regulations adopted thereunder and with regulations relating to the encryption adopted by the federal Centers for Medicare and Medicaid Services and which satisfy federal requirements relating to efficiency, economy and quality of care.

1-006.08 Out-of-State Telehealth Services are covered:

1. When the distant site is located in another state and the originating site is located in Nebraska if the requirements listed in the regulations at 471 NAC 1-002.02G are met.
2. When the Nebraska client is located at an originating site in another state, whether or not the provider's distant site is located in or out of Nebraska if the requirements listed in the regulations at 471 NAC 1-002.02G are met.

1-006.09 Documentation: The medical record for telehealth services must follow all applicable statutes and regulations on documentation. The use of telehealth technology must also be documented in the same medical record, and must include the following telehealth information:

1. Documentation of which site initiated the call;
2. Documentation of the telecommunication technology utilized (e.g. real-time two-way interactive audio-visual transmission via a T1 Line); and
3. The time the service began and ended.



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3. Fully meet standards established by the federal Department of Health and Human Services, and any applicable state and federal laws governing the provision of their services;
4. Provide services according to the regulations and procedures of the Department for NMAP;
5. Provide services in compliance with Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973;
6. Accept as payment in full the amount paid in accordance with the rates established by the Department after all other sources (including third party resources, Medicare, or excess income) have been exhausted. Exception: If a client resides in a nursing facility, a payment to the facility for the client to occupy a single room is not considered income in the client's budget if Medicaid is or will be paying any part of the nursing facility care;
7. Submit charges to the Department which do not exceed the provider's charges to the general public;
8. Submit claims which are true, accurate, and complete;
9. Maintain records on all services provided for which a claim has been made, and furnish, on request, the records to the Department, the federal Department of Health and Human Services, and the federal or state fraud and abuse units. Providers shall document services rendered in an institutional setting in the client's institutional chart before billing the Department;
10. Submit claims electronically, if applicable, under proper signature of the provider or the provider's authorized representative;
11. Maintain computer software used in the submission of claims and furnish, on request, the documentation to the Department, the federal Department of Health and Human Services and the federal or state fraud and abuse units;
12. Follow the submittal procedures, record layout requirements, service verification requirements, and provider and/or authorized representative certification requirements for the electronic submission of claims; and
13. A provider shall not establish a policy to automatically waive co-payment or deductibles established by the Department.

Failure to meet these requirements may result in termination or suspension of the provider agreement (see 471 NAC 2-002).

Signing the provider agreement and enrolling in NMAP does not constitute employment.



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2-001.03A Signature Date of Provider Agreement: A provider agreement must be signed and on file with the Department before payment for services is made. Payment may be made for covered services provided before the signature date of the agreement if the agreement is signed and on file with the Department before payment and the provider met all eligibility requirements at the time the service was provided.

2-001.03B Required Forms: Providers shall complete the appropriate form listed below and submit the signed form to the Department:

14. Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90);
15. Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91); or
16. Form MC-81, "Medical Assistance SNF/ICF/ICF-MR Provider Agreement," (see 471-000-104).

Certain providers of home and community-based services are required to complete provider agreement forms as indicated in Title 480. Certain providers of medical transportation services are required to complete the provider agreement form as indicated in Titles 473 and 474.

The Department does not accept provider agreements that have been altered in any way. An altered agreement will be returned to the potential/current provider; a new agreement will be required or participation in NMAP will be terminated.

NMAP may require a new agreement to update information and/or eligibility. The appropriate form will be required to secure and maintain an updated agreement on file for each provider. If an updated agreement is requested by the Department, the provider shall complete and sign the updated agreement.

2-001.03C Approval and Enrollment: Submitted provider agreements are reviewed before approval and enrollment. A Medicaid provider number is assigned. This number is used for billing Medicaid.

2-001.04 Standards for Participation: Providers shall meet the following minimum standards:

1. Accept the philosophy of service provision which includes acceptance of, respect for, and a positive attitude toward Medicaid clients and the philosophy of client empowerment;
2. Meet any applicable licensure or certification requirements and maintain current licensure or certification;
3. Obtain adequate information on the medical and personal needs of each client, if applicable;

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4. Not discriminate against any client, employee, or applicant for employment because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90, and 41 CFR Part 60;
5. Agree to a law enforcement check and Adult Protective Services and Child Protective Services Central Registry checks;
6. Operate a drug-free workplace;
7. Attend training on the NMAP as deemed necessary by the Department;
8. Provide services within the scope of practice under applicable licensure or certification requirements; and
9. Agree to maintain up-to-date and accurate provider agreement information by submitting any changes to the Department.

Employees of providers are subject to the same standards.

2-001.05 Employees as Providers: No employee of the Department and its subdivisions, except clinical consultants, may serve as providers of medical services under the Nebraska Medical Assistance Program or as paid consultants to providers under the Nebraska Medical Assistance Program without the express written approval of the Director.

2-001.06 Principles of Providing Medical Assistance: Medical care and services are provided through NMAP to maintain good physical and mental health, to prevent physical disease and disability, to mitigate disease, and to rehabilitate the individual. The amount and type of service required is defined for each case through utilization review. The provider shall limit services to essential health care. The plan for providing services within program guidelines through NMAP is based on the following principles:

1. All plans for medical care must provide for essential health services and for integration of treatment with social planning to reduce economic dependency;
2. Medical care and services must be coordinated with health services available through existing public and private sources;
3. Medical care and services must be provided as economically as is consistent with accepted standards of medical care and fair compensation to providers;
4. Medical care and services must be within the licensure of the provider giving the care or service; and
5. The client must be allowed, within these limitations, to exercise free choice in the selection of a qualified provider.

2-001.07 Provider Handbooks: The Department issues provider handbooks for specific provider types addressed in this Title. Each provider handbook contains –

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NMMCP: The Nebraska Medicaid Managed Care Program (see Title 482 NAC).

Open-Ended Provider Agreement: An agreement that has no specific termination dates and continues in force as long as it is agreeable to both parties.

Overutilization: A documented pattern of ordering or performing and billing tests, examinations, medical visits, and/or surgeries, drugs and merchandise for which there is no demonstrable need, when the determination of demonstrable need is made by the Medicaid Medical Director or consultants.

Participation: Participation in NMAP includes providing, referring, furnishing, ordering, or prescribing services to a Medicaid client or causing services to be provided, referred, furnished, ordered, or prescribed for a Medicaid client.

Payment: Reimbursement or compensation by the Department, its agents, or assignees, e.g., managed care plans.

Person: Any individual, company, firm, association, corporation, or other legal entity.

Provider: Any person which furnishes Medicaid goods or services under an approved provider agreement with the Department.

Proper Patient Waiver: An agreement by which the client or client's legal representative agrees to release his/her medical records to state or federal authorities accomplished by the client signing Form DA-100, "Application for Assistance."

Suspension from Participation: An exclusion from participation in NMAP for a specified period of time.

Suspension of Payments: Withholding of payments due a provider until the resolution of the matter in dispute between the provider and the Department.

Termination from Participation: A permanent exclusion from participation in NMAP.

Trading Partner Agreement (TPA): An agreement related to the electronic exchange of information.

Trading Partner: A health care plan, provider or clearinghouse that transmits any health information in electronic form.

Underutilization: Lack of treatment/referrals when there is a demonstrable need, when the determination of demonstrable need is made by the Medicaid Medical Director or consultants.

Usual and Customary Charge: Charge to the general public.



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Withholding of Payments: A reduction or adjustment of the amounts paid to the provider on pending and subsequently submitted claims to offset overpayments previously made to the provider.

2-002.03 Reasons for Sanctions: The grounds for the Department to impose sanctions upon a provider include, but are not limited to, the following:

1. Presenting, or causing to be presented, any false or fraudulent claim for goods or services or merchandise for payment;
2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater payment than that to which the provider is legally entitled;
3. Billing in excess of the usual and customary charges;
4. Altering medical records to obtain a higher classification of the client than is truly warranted;
5. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization/approval requirements, or obtaining payments prior to the effective date;
6. Failing to disclose or make available to the Department, or its authorized representatives, records of services provided to NMAP clients and records of payments by the Department, its agents and others made for those services, when requested;
7. Failing to provide and maintain quality, necessary, and appropriate services within accepted medical standards as determined by a body of peers, as documented by repeat deficiencies noted by the survey and certification agency, a peer review committee, medical review teams, or independent professional review teams, or by the determination of the Medicaid Director and/or consultants, or the Department or its designee, the Department's Quality Assurance Committee, any Department Inspection of Care, or a managed care plan's quality assurance committee;
8. Breaching the terms of the Medicaid provider agreement or submitting false or fraudulent application for providing participation;
9. Violating any provision of the Nebraska laws regarding NMAP or any rule or regulation of NMAP;
10. Failing to comply with the terms of the provider certification on the Medicaid claim form;
11. Overutilizing the Medicaid program by inducing, furnishing, or otherwise causing a client to receive services or merchandise not otherwise required by the client, ordered by the attending physician, or deemed appropriate by utilization review committee. Note: A determination of overutilization may be based on a comparison of treatment practices of a specific provider compared to peers for similar types of clients;

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12. Underutilizing the Medicaid program by not furnishing required services;
13. Presenting a claim, billing, or causing a claim to be presented for payment for services not rendered (including "no-shows");
14. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;
15. Soliciting, offering, or receiving a kickback, bribe, or rebate;
16. Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries;
17. Failing to meet standards required by state or federal law for participation (e.g., licensure and/or certification);
18. Not accepting Medicaid payment as payment in full for covered services and collecting or attempting to collect additional payment from others, the client or responsible person, or collecting a portion of the service fee from the client or the client's family, except for required co-payments;
19. Refusing to execute a new provider agreement at the Department's request, failing to update as required in 471 NAC 20-001.09C, 32-004.03A, and 35-002 or failing to update provider agreement information when changes have occurred;
20. Failing to correct deficiencies in operations or improper billing practices after receiving written notice of these deficiencies/practices from the Department or its agent (for example, HHS Regulation and Licensure for home and community-based waivers, managed care plans);
21. Being formally reprimanded or censured by an association of the provider's peers for unethical practices;
22. Being suspended or terminated from participation in another governmental medical program such as Worker's Compensation, Medically Handicapped Children's Program, Vocational Rehabilitation Services, Medicare, or Medicaid in another state or a Medicaid managed care plan; being convicted for civil or criminal violations of NMAP, or any other state's Medicaid (medical assistance) program; or having sanctions applied by the Department's agents or assignees or any other state's Medicaid program;
23. Failing to repay or make arrangements for the repayment of overpayments or otherwise erroneous payments;
24. Submitting duplicate bills, including billing NMAP twice for the same service, or billing both NMAP and another insurer or government program;
25. Billing before the goods or services are provided or dispensed prior to the date of billing (pre-billing);

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26. Any action resulting in a reduction or depletion of a nursing facility or ICF/MR Medicaid client's personal allowance funds or reserve account (liquid assets) unless specifically authorized in writing by the client, or legal representative;
27. Billing for services provided by non-enrolled providers, sanctioned providers, or excluded persons;
28. Billing for services rendered by someone else as though the provider performed the services him/herself;
29. Billing for services provided by an individual who is required to be licensed or certified and who did not meet that requirement when the service was provided;
30. Billing for services provided outside the provider's scope of practice;
31. Upgrading services billed and rendered from those actually ordered;
32. Upcoding services billed or billing a higher level of service than those actually provided;
33. Reporting of unallowable cost items on a provider's cost report or reporting any item which is obviously unallowable except when the unallowable entry was included in the cost report only to establish a basis for appeal;
34. Violating conditions of an exclusion;
35. Violating conditions of probationary or restricted licensure;
36. Not having the appropriate Drug Enforcement Administration (DEA) license or state drug license;
37. Loss, restriction, or lack of hospital privileges;
38. Failure or inability to provide and maintain quality, necessary and appropriate services due to physical or mental health conditions of the service provider;
39. Endangering health and safety of clients;
40. Failure to obtain or maintain required surety bond(s);
41. Failure to provide Department with documentation of authorization for third party to submit claims for the provider for payment to the Department or failing to update this information when changes have occurred; or
42. Breaching the terms of a Trading Partner Agreement to exchange information electronically.

2-002.04 Sanctions: The Department may invoke one or more of the following sanctions against a provider based on 471 NAC 2-002.03:

1. Termination from participation in the Medicaid program;
2. Suspension of participation in the Medicaid program;

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3. Suspension or termination of participation in the NMMCP (NHC);
4. Suspension or withholding of payments to a provider;
5. Recoupment from future provider payments;
6. Transfer to a closed-end provider agreement not to exceed 12 months, or the shortening of an already existing closed-end provider agreement; or
7. Attendance at provider education sessions.

2-002.04A Excluded Persons: The Department may exclude non-participating persons based on 471 NAC 2-002.03; this includes, but is not limited to, billing agents, clearinghouses, and accountants.

2-002.05 Imposition of a Sanction: The decision on the sanction to be imposed is at the discretion of the Director. The following factors are considered in determining the sanctions to be imposed:

1. Seriousness of the offenses;
2. Extent of violations;
3. History of prior violations;
4. Prior imposition of sanctions;
5. Prior provision of provider education;
6. Provider willingness to comply with program rules;
7. Whether a lesser sanction will be sufficient to remedy the problem; and
8. Actions taken or recommended by peer review groups and licensing boards.

The Department shall notify the provider at least 30 days before the effective date of the sanction, unless extenuating circumstances exist. The Department shall give the provider an opportunity to submit additional information or to appeal the sanction. The provider must file the appeal within 30 days of the date of the notice of the sanction. When the clients' health and safety is threatened, appropriate administrative sanctions may be taken without a full evidentiary hearing. The provider may file an appeal regarding this action; however, the sanction will remain in effect until the hearing decision is made. When a sanction is imposed, the Department shall give general notice to the public of the restriction, its basis, and its duration.

To prevent inappropriate Medicaid payments or to avoid further overpayments, the Department may sanction a provider by suspending the provider's payments with an immediate effective date. The Department will notify the provider by letter that its payments have been suspended. The provider may file an appeal regarding this action; however, the suspension of payments will remain in effect until the hearing decision is made.

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If a provider participates under one or more provider number, or changes numbers, payments can be suspended, withheld or recouped from one or all of the provider numbers.

2-002.05A Conditions of Suspension or Termination: When a provider is suspended or terminated from NMAP, NMAP may not make reimbursement for services, items, or drugs that are provided, referred, furnished, or prescribed by the suspended or terminated provider or caused to be provided, referred, furnished, ordered, or prescribed for a Medicaid client.

A Medicaid client may not be billed for any services provided, referred, furnished, ordered, or prescribed by an excluded provider.

Exception: NMAP may pay claims from a submitting provider, such as a pharmacy, until the submitting provider and the client are notified of the suspension or termination of the prescribing/attending provider. NMAP may pay claims for emergency medical services when Medicaid Division staff or consultants determine that the services were medically necessary.

2-002.05B Sanction of Affiliates: The Department may sanction all known affiliates of a provider when each decision to include an affiliate is made on a case by case basis after considering all relevant facts and circumstances. The Department may determine the affiliate's violation, failure, or inadequacy of performance when the provider's action which resulted in a sanction took place in the course of the affiliate's official duty or with the knowledge or approval of the affiliate.

2-002.05C Claims Submitted by an Excluded Provider: Suspension or termination from participation of any provider shall preclude the provider from submitting claims for payment, either personally or through any clinic, group, corporation, or other association, to the Department for any services or supplies provided under NMAP, except for those services or supplies provided before the suspension or termination.

2-002.05D Excluded Person: No clinic, group, corporation, or other association which is a provider of services shall submit claims for payment to the Department for any services or supplies provided by a person within the organization which has been excluded from participation in NMAP except for those services or supplies provided before the suspension or termination. If these provisions are violated by a clinic, group, corporation, or other association, the Department may suspend or terminate the organization and/or any individual person within the organization responsible for the violation.

A provider shall not submit any claims to NMAP that contain the costs of services provided by excluded persons.



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2-002.05E Notification of Other Agencies: When a provider has been sanctioned, the Department shall notify, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

2-002.05F Notification of Local HHS Offices: When a provider's participation in NMAP has been suspended or terminated, the Department will notify the local HHS offices of the suspension or termination.

2-002.05G Provider Education: A provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include –

1. Telephone and written instructions;
2. Provider manuals and workshops;
3. Instruction in claim form completion;
4. Instruction in the use and format of provider manuals;
5. Instruction in the use of procedure codes;
6. Key provisions of the Medicaid program;
7. Instructions on reimbursement rates; and
8. Instructions on how to inquire about coding or billing problems.

2-002.05H Denial of Enrollment: At the discretion of the Department, providers who have previously been terminated or suspended may or may not be re-enrolled as providers of Title XIX (Medicaid) services.

2-002.05J Reinstatement: At the end of the suspension period, the provider may request in writing that the Department reinstate his/her provider agreement. The Medicaid Division may approve or deny reinstatement of the provider agreement. The provider may be reinstated conditionally with a closed-end provider agreement or other restrictions or requirements.

2-002.06 Audits: All services for which claims for payment are submitted to the Department are subject to audit. During a review audit, the provider shall furnish to the Department, or its authorized representative, pertinent information regarding claims for payment. If an audit reveals that incorrect payments were made or that the provider's records do not support payments that have been made, the provider shall make restitution.

2-002.06A Sampling and Extrapolation: The Department's procedure for auditing providers may involve the use of sampling and extrapolation. Under this procedure, the Department selects a statistically valid sample of the services for which the provider received payment for the audit period in question and audits the provider's records for these services.

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All incorrect payments determined by an audit of the services in the sample are totaled and extrapolated to the entire universe of services for which the provider has been paid during the audit period. The provider shall pay to the Department the entire extrapolated amount of incorrect payments calculated under this procedure after notice and opportunity for hearing under 471 NAC 2-002.05 and 2-003.

2-002.06B Hearings: The Department shall allow the provider an opportunity to rebut the Department's audit findings. If the findings are based on sampling and extrapolation, the provider may present an independent 100% audit of his/her Medicaid payments during the audit period in lieu of accepting the Department's sampling and extrapolation. Any audit of this type must demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with the Department's regulations. The provider must be prepared to submit supporting documentation to demonstrate this compliance.

2-003 Provider Hearings

2-003.01 Right to Appeal: Every provider of medical services has a right to appeal to the Director of the Department for a hearing on an action taken by the Department which has a direct adverse effect on the provider. Decisions of the medical review organization must first be reconsidered by the medical review organization. These actions may include but are not limited to, reductions or disallowances of claims, retroactive (year-end) adjustments, and administrative sanctions, including suspension or termination.

2-003.02 Request for a Hearing: A provider shall request a hearing within 90 days of the date of the action. Administrative sanctions must be appealed within 30 days of the date of the notice of the sanction. Requests for refunds must be appealed within 30 days of the date of the action. The date of the action is the original request date as indicated on the Refund Request Report MCP-248, or the date of the letter which notified the provider of the action.

2-003.02A Suspension or Termination: If the provider has been notified by the Department of a proposed suspension or termination, the provider may request a hearing before the effective date of the proposed suspension or termination, and the suspension or termination will not take effect until after the hearing decision has been made. If the provider requests a hearing after the suspension or termination has taken effect, the suspension or termination will remain in effect until after the hearing decision has been made.

2-003.03 Filing a Request: If the provider wishes to appeal an action of the Department, the provider must submit a written request for an appeal to the Director of the Department. The provider shall identify the basis of the appeal in the request.

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2-003.04 Scheduling a Hearing: When the Director receives a request for a hearing, the request is acknowledged by a letter which states the time and date of the hearing.

2-003.05 Hearings: Hearings are scheduled and conducted according to the procedures contained in 465 NAC 6-000.

2-003.06 Long Term Care Facilities Appeals Process

2-003.06A Appeal of Denial, Termination, or Non-Renewal of Certification:

Any nursing facility or intermediate care facility for the mentally retarded (ICF/MR) whose Medicaid certification has been denied, terminated, or not renewed may appeal to the Nebraska Department of Health and Human Services Regulation and Licensure (HHS Regulation and Licensure), which will conduct the hearings under Rule 56 of the Rules of Practice and Procedure adopted by HHS Regulation and Licensure.

2-003.06B Skilled Nursing Facility (SNF) Medicare/Medicaid Participation:

If an SNF is participating, or seeking to participate, in both Medicare and Medicaid, and if the basis for the Department's denial, termination, or non-renewal of participation in Medicaid is also a basis for denial, termination, or non-renewal in Medicare, the facility is entitled to the review procedures specified for Medicare facilities under 42 Code of Federal Regulations (CFR) Part 405 Subpart O. The final decision entered under the Medicare review procedures will be binding for purposes of Medicaid NF participation. If the SNF is also certified for Medicaid NF participation, a separate appeal must be made to HHS Regulation and Licensure.

2-003.06C Appeal of Denial, Termination, or Non-Renewal of Medicaid Provider Agreements: Any NF or ICF/MR whose Medicaid provider agreement has been denied, terminated, or not renewed may appeal to the Director for a hearing under this section.

2-004 Client Lock-In: The Department investigates clients who through utilization review, provider referral, or local office referral are identified as mis-utilizing medical assistance services. If the investigation establishes that the client has abused or overutilized services provided through the Nebraska Medical Assistance Program, the client may be locked-in. The Department's Utilization Review Committee makes the decision to lock-in a client.

2-004.01 Definition of Lock-In: Lock-in is a method used by the Department to ensure appropriate utilization of medical services by a client who has been determined to be abusing or overutilizing services provided by NMAP without infringing on the client's free choice of a provider.

2-004.02 Lock-In Categories: The client may be locked-in to one of the following categories: Note: Payment for medical emergencies and referrals to other physicians may be covered under 471 NAC 2-004.04.



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2-004.02A Category 1: One pharmacy. The client chooses one pharmacy. The Department will approve payment for prescriptions only from that pharmacy. Other covered services are not restricted.

2-004.02B Category 2: One primary physician and one pharmacy. The client chooses one primary physician and one pharmacy.

2-004.02C Category 3: One primary physician, one pharmacy, and one hospital. The client chooses one primary physician, one pharmacy, and one hospital for outpatient services. Inpatient hospital admissions are exempt.

2-004.02D Category 4: One prescribing physician and one pharmacy. The client chooses one prescribing physician and one pharmacy. Only prescriptions authorized by the prescribing physician and dispensed by the pharmacy will be approved for payment. This category allows the client to visit other physicians without restriction.

2-004.02E Category 9: All types of service. The client must choose only one provider for each type of service she/he wishes to receive.

2-004.03 Choice of Lock-In Provider(s): The client is allowed to choose the provider(s). The primary physician or the prescribing physician must be an individual, as opposed to a partnership, clinic, teaching institution, or hospital staff.

A client in the lock-in program who is enrolled in the Nebraska Health Connection is allowed to choose his/her provider. The provider chosen as the lock-in provider must be the provider who is the client's primary care physician (PCP) under NHC.

2-004.03A Change of Primary Provider: The choice of provider(s) may be changed at any time upon demonstration by the client of good cause, which is determined by the Utilization Review Committee. The client is allowed to change the provider(s) every three months without demonstration of good cause. All requests for change must be submitted to the Utilization Review Committee through the local office by submitting a revised Form MC-66, "Recipient Choice of Provider Agreement."

2-004.04 Services by Other Providers: Claims for services provided to a lock-in client by other than the chosen provider(s) will not be approved, with the following exceptions:

2-004.04A Medical Emergencies: Emergency care is defined as medically necessary services provided to an individual who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions. The provider shall document in writing any emergency situation. The documentation must be attached to any claim submitted to the Department.

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2-004.04B Primary Physician Referrals: A primary physician may make a written referral of a lock-in client to another physician, dentist, osteopath, or podiatrist. Claims submitted may be approved for payment if a copy of the written referral from the primary physician is attached to the claim. Lock-in referrals may be approved for a reasonable amount of time for the condition being treated. If this time is exceeded, the Department may require a new referral letter from the primary physician.

2-004.04C Other Medical Services: Services by providers other than physicians, osteopaths, dentists, and podiatrists do not require a written referral from the primary physician.

2-004.05 Lock-In Notification: The Utilization Review Committee notifies the client, the client's local office, and Nebraska Health Connection (NHC) if the client is participating in NHC (or current enrollment broker for managed care) of the lock-in restriction through Form MC-38 at least ten days before imposing lock-in. Form MC-38:

1. Explains the lock-in restriction, stating that the restriction does not apply to emergency services furnished to the client;
2. Provides reasons for the lock-in;
3. Provides appropriate manual references;
4. Informs the client and local office of the client's right to an appeal hearing; and
5. Explains that the client has 90 days to request a hearing in writing, and that if the client requests a hearing in writing within 10 days, the Lock-In will be delayed until a hearing decision is rendered.

2-004.05A Client Appeal Rights: The lock-in client has the right to appeal for a hearing. The client or the client's representative has 90 days following the date of notification to request a hearing in writing. If a hearing is requested in writing within ten days following the date of notification, the lock-in restriction will be delayed until a hearing decision is rendered.

2-004.06 Lock-In Agreement: Within ten working days following the date of the lock-in notification, the local office, NHC or client shall submit Form MC-66, "Recipient Choice of Provider Agreement," (see 471-000-93) to the Utilization Review Committee. The client and witness shall sign the agreement. The agreement identifies the provider(s) chosen by the client and states that the chosen provider(s) will be the only provider(s) of service.

2-004.06A Failure to Provide Agreement: Failure by the lock-in client or the local office to provide the agreement will result in the Department designating the provider(s) for the client or restricting the eligibility of the client to "emergency services only" (see 471 NAC 2-004.07).



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2-004.06B Effective Date of Lock-In Agreement: The effective date of the lock-in agreement is either: 1) The first day of the month following the month in which the client signed the agreement; or 2) The date the agreement is signed, if requested by the lock-in client, caseworker or NHC and approved by the state; or 3) Another date, if requested by the lock-in client, caseworker or NHC and approved by the state.

2-004.07 Eligibility Information: Lock-in status may be verified by accessing the Department Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580) (see 471-000-124); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128), or electronically by using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

If “emergency services only” is indicated, the provider may render only emergency services. The provider shall document in writing any emergency situation and the documentation must accompany any claim submitted to the Department for payment.

2-004.07A Provider Determination of Lock-In Status: The provider shall determine the client’s lock-in status by accessing the Department Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or electronically by using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). NMES will allow the provider to obtain current eligibility information (including lock-in status) and is operational 24 hours per day, seven days per week. (See 471-000-124 for instructions on using NMES.)

When a client initially becomes eligible for medical assistance, she/he may not have a Medicaid Identification Card at the time of the appointment. The provider shall verify the eligibility of the client(s) by contacting one of the eligibility verification systems listed above or the local office, or by using the standard electronic transaction.

2-004.08 Pharmacy Claims: Pharmacy claims submitted for prescriptions dispensed to a lock-in client by providers other than those designated on the Nebraska Medicaid Eligibility System may not be paid except in a bona fide emergency. The pharmacy shall document in writing the emergency situation.

Due to the circumstances necessitating the lock-in, the Department will approve for payment only prescriptions authorized by the primary or prescribing physician. Prescriptions by other practitioners (dentist, podiatrist, referral physician, etc.) will not be approved unless the primary or prescribing physician authorized them.



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2-004.09 Client's Lock-In File: The Utilization Review Committee maintains a complete case file for each lock-in client at the Central Office. The client or the client's representative may request in writing a copy of all information contained within this file.

2-004.10 Review of Lock-In Status: The Utilization Review Committee, or its designee, will review the client's lock-in status every 24 months on the continued appropriateness of the lock-in.

At least 10 days before lock-in is extended, the Utilization Review Committee notifies the client, the client's local office, and Nebraska Health Connection if the client is participating in NHC (or current enrollment broker for managed care) of the review of the client's lock-in status. The notice:

1. Explains the outcome(s) of the review, which may include continuing lock-in status for another 24 months, changing lock-in category (see 471 NAC 2-004.02), or removing lock-in status;
2. Provides reasons for the outcome(s), according to the criteria listed in 471 NAC 2-004.10A;
3. Provides appropriate manual references;
4. Informs the client, local office and NHC of the client's right to an appeal hearing; and
5. Explains that the client has 90 days to request a hearing in writing, and that if the client requests a hearing in writing within 10 days, no change will be made until a hearing decision is rendered.

2-004.10A: The client's lock-in status may be continued, changed or removed following the review of lock-in status based on the following reasons:

1. Use of controlled substances, carisoprodol, tramadol or other drug(s) with abuse potential; or
2. Early prescription refills, as defined in the drug claim processing system; or
3. Use of drugs which are known to interact with other drugs, diseases, conditions or foods; or
4. Use of medications indicating multiple medical conditions with complex medication regimens; or
5. Patient safety, including use of medication(s) with narrow therapeutic index;
6. Abuse or overuse of medical services; or
7. History of drug abuse, medication-seeking behavior, non-compliance, emergency room overuse or abuse; or

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8. Coverage by Medicaid of services from non-lock-in providers in non-emergency situations; or
9. Report(s) of obtaining Medicaid coverable drugs by paying cash; or
10. Other similar reasons.

In addition to the biennial review, the client or the client's primary physician may request a review of the client's lock-in status. Any request for review must contain a statement from the client's primary physician indicating that the client's medical history and/or treatment plan has been completely reviewed and stating the change in lock-in status being recommended, along with reasons supporting this recommendation. The Utilization Review Committee will notify the lock-in client, local office and NHC, if the client is participating in NHC, of its decision within ten days from the date the request is received. Requests for review of lock-in status will be limited to once per year, unless the client can demonstrate good cause. Good cause will be determined by the Utilization Review Committee.

2-005 Advance Directives: An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (statutory or as recognized by the courts of the state) that relates to the provision of medical care if the individual becomes incapacitated.

All Medicaid-participating hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations, and health insuring organizations shall comply with this section. They shall –

1. Maintain written policies, procedures, and materials concerning advance directives;
2. Provide written information (see 471-000-304) to all adult (as defined by state law) individuals receiving medical care by or through the provider or organization concerning their rights under state law to -
 - a. Make decisions concerning their medical care;
 - b. Accept or refuse medical or surgical treatment; and
 - c. Formulate advance directives, such as living wills or durable power of attorney for health care;
3. Provide written information to all adult individuals on the provider's policies concerning implementation of these rights;
4. Document in the individual's medical record whether the individual has executed an advance directive;
5. Not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive;

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6. Ensure compliance with requirements of state law (whether statutory or as recognized by the courts of the state) concerning advance directives; and
7. Provide for educating staff and the community on advance directives.

2-005.01 When Providers Give Information Concerning Advance Directives:

Providers shall give information concerning advance directives to each adult patient as follows:

1. A hospital shall give information at the time of the individual's admission as an inpatient;
2. A nursing facility shall give information at the time of the individual's admission as a resident;
3. A provider of home health care or personal care services shall give information to the individual in advance of the individual's coming under the care of the provider;
4. A hospice program shall give information at the time of initial receipt of hospice care by the individual; and
5. An HMO/HIO shall give information at the time the individual enrolls with the organization, i.e., when the HMO enrolls or re-enrolls the individual. If an HMO has more than one medical record for its enrollees, it must document all medical records.

2-005.02 Information Concerning Advance Directives at the Time an Incapacitated Individual Is Admitted:

An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether she/he has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it shall also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once she/he is no longer incapacitated.

2-005.03 Previously Executed Advance Directives: When the patient or a relative, surrogate, or other concerned or related individual presents the facility with a copy of the individual's advance directive, the facility shall comply with the advance directive to the extent allowed under state law. This does not preclude a facility from objecting as a matter of conscience, if it is permitted to do so under state law.

Absent contrary state law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether she/he has executed an advance directive, the facility shall note that the individual was not able to receive information and was unable to communicate whether an advance directive existed.



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2-006 Disclosure of Information by Providers: Under 42 CFR 455, Subpart B, the Department requires that providers disclose information on –

1. Ownership and control;
2. Business transactions; and
3. The providers' owners and other persons convicted of crimes against Medicare, Medicaid, or Title XX (Social Services Block Grant) programs.

2-006.01 Ownership and Control: Providers are required to disclose -

1. The name, address, Employer Identification Number or social security number of:
 - a. Each person with an ownership or control interest in the entity or any subcontractor in which the provider directly or indirectly has a five percent or more ownership interest; and
 - b. Any managing employee of the entity;
2. Whether any of the persons named in compliance with the above paragraph is related to another as spouse, parent, child, or sibling; and
3. The name of any other entity in which a person named in 471 NAC 2-006.01(1) has an ownership or controlling interest.

For purposes of this section, "person with an ownership or control interest" means, with respect to an entity, a person who:

1. a) Has directly or indirectly an ownership interest of five per centum or more in the entity;
- b) Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds five per centum of the total property and assets of the entity; or
2. Is an officer or director of the entity, if the entity is organized as a corporation; or
3. Is a partner in the entity, if the entity is organized as a partnership.

The term "managing employee" means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

Any provider that is subject to periodic survey and certification of its compliance with Medicaid standards shall supply this information to the Department at the time it is surveyed. Any provider that is not subject to periodic survey and certification shall supply the information before entering into an agreement with the Department.

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The Department shall not approve a provider agreement, and shall terminate an existing agreement, if the provider fails to disclose ownership or control information. The Department shall not pay a provider who fails to disclose ownership or control information.

A provider shall notify the Department of any changes or updates to the information supplied under 471 NAC 2-006.01 not later than 35 days after such changes or updates take effect.

2-006.02 Business Transactions: When requested, providers shall disclose, within 35 days of the date on the request, full and complete information on –

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending with the date of the request; and
2. Any significant business transaction between the provider and any wholly-owned supplier, or between the provider and any sub-contractor, during the five-year period ending on the date of the request.

The Department shall not pay providers who fail to comply with a request for this information, or pay for services provided during the period beginning on the day following the date the information was due to the Department and ending on the day before the date the Department received the information.

2-006.03 Persons Convicted of Crimes: Before the Department enters into or renews a provider agreement, or upon request, the provider shall disclose to the Department the identity of any person who –

1. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
2. Has been convicted of a criminal offense related to that person's involvement in any problem under Medicare, Medicaid, or the Social Services Block Grant (Title XX) programs since the inception of those programs.

The Department may refuse to enter into or renew a provider agreement if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Social Services Block Grant (Title XX). The Department may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately disclose this information.



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CHAPTER 3-000 PAYMENT FOR MEDICAID SERVICES

3-001 Definitions:

Claim means a request for payment for services rendered or supplied by a provider to a client.

Clearinghouse means an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction and receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard or nonstandard data content for the receiving entity.

HCPCS means the Healthcare Common Procedure Coding System. This contains the national codes adopted by the federal Secretary of Health and Human Services and includes American Medical Association's Current Procedural Terminology (CPT) Level 1 procedure codes and Level 2 procedure codes.

Indian means an individual, defined at 25 U.S.C. sections 1603(c), 1603(f), and 1679(b), or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization – I/T/U) or through referral under Contract Health Services.

Indian Health Care Provider means a health care program, including contract health services, operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined 25 U.S.C. 1603.

Standard Transaction means an electronic transaction that complies with the applicable standard adopted under federal law.

Transaction means the exchange of information between two parties to carry out financial or administrative activities related to health care.

Trading Partner Agreement (TPA) means an agreement related to the electronic exchange of information.

Warrant means a paper check or electronic funds transfer.

3-002 Approval and Payment

3-002.01 Approval: Payment for medical care and services through Medicaid funds must be approved by the Department. Claims will be approved for payment when all of the following conditions are met:

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1. A provider agreement is on file with the Department, as well as the certification and transmittal from the state licensing agency or the Centers for Medicare and Medicaid Services (CMS) Regional Office when required;
2. The client was eligible for Medicaid when the service was provided, or the service was provided during the period of retroactive eligibility;
3. No more than 6 months have elapsed from the date of service when the claim is received by the Department (see 471 NAC 3-002.01A for exceptions);
4. The medical care and services are within the guidelines of Medicaid;
5. The client's case record must contain information to meet state requirements; and
6. A trading partner agreement has been approved, if required, for clearinghouses, billing agents, and providers submitting claims using electronic transactions.

3-002.01A Exceptions: Payment may be made by the Department for claims received more than 6 months after the date of service if the circumstances which delayed the submittal were beyond the provider's control. Some circumstances that are considered by the Department to be beyond the provider's control include, but are not limited to –

1. Provider's eligibility;
2. Client's retroactive eligibility;
3. Client's failure to submit appropriate information;
4. Unusual Central Office delay; or
5. Third party casualty situations (see 471 NAC 3-004.06C).

The Department shall determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

Payment may be made by the Department for claims that are received within one year after the date of service for Medicaid-approved special education services provided by school districts, as authorized by Neb. Rev. Stat. § 43-2511.

3-002.01B Timely Payment of Claims: The Department shall pay claims within 12 months of the date of receipt of the claim. This time limitation does not apply to –

1. Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system;
2. Claims which have been filed in a timely manner for payment by Medicare, for which the Department may pay a Medicaid claim relating to the same services. Claims for the Medicaid portion must be submitted to the Department within six months from the date of the Medicare remittance advice;

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3. Claims from providers under investigation for alleged fraud or abuse;
4. Payments made -
 - a. In accordance with a court order;
 - b. To carry out hearing decisions or agency corrective actions taken to resolve a dispute;
 - c. To extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it; or
5. Third party casualty situations as specified in 471 NAC 3-004.06C.

3-002.01C Denial: The Department shall not pay claims received more than two years after the date of service, except under the circumstances specified in 471 NAC 3-002.01B or 3-004.06B.

3-002.01D Provider's Failure to Cooperate in Securing Third Party Payment: The Department may deny payment of a provider's claims if the provider fails to apply third party payments to medical bills, to file necessary claims, or to cooperate in matters necessary to secure payment by insurance or other liable third parties.

3-002.02 Payment

3-002.02A Upper Limits: The Department has established upper limits for payment as described in each provider chapter.

3-002.02B Coverage Exception: Certain medical services, while being medically necessary, may exceed the NMAP coverage guidelines which have been established by the Department. Under these circumstances, the determination of medical necessity for payment purposes is based upon the professional judgment of the Department's consultants and other appropriate staff.

3-002.02C Payment in Full: Providers participating in NMAP shall agree to accept as payment in full the amount paid according to the Department's payment methodologies after all other sources have been exhausted.

Exception: If a client resides in a nursing facility, a payment to the facility for the client to occupy a single room is not considered income in the client's budget if Medicaid is or will be paying any part of the nursing facility care.

3-002.02D Charges to the General Public: Providers shall not exceed their charges to the general public when billing NMAP. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to Medicaid clients who would otherwise qualify for the discount.

3-002.02E Method of Payment: Effective January 1, 2009, payment for all approved medical services within the scope of NMAP will be made by electronic funds transfer (EFT) to the provider who supplied the services.



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3-002.02F Billed Charges: If the provider's billed charges are less than the Department's allowable payment, the Department pays the provider's billed charges.

Exception: Inpatient hospital services are paid on a diagnosis-related group (DRG) or per diem basis, regardless of billed charges.

3-002.03 Post-Payment Review: Payment for a service does not indicate compliance with NMAP policy. Monitoring may be accomplished by post-payment review to verify that NMAP policy has been followed. A refund will be requested if post-payment review finds that NMAP payment has been made for claims/services not in compliance with NMAP policy. During a post-payment review, claims submitted for payment may be subjected to further review or not processed pending the outcome of the review.

3-002.04 Payment for Medical Expenses: Payment may not be made from NMAP funds for medical expenses which have been paid from county funds or other public or private sources.

3-002.05 Excess Income/Share of Cost: Individuals who are otherwise eligible but who have excess income shall obligate the excess amount for medical care before payment for medical services can be approved through NMAP. Obligation or payment of the excess amount is documented on Form DSS-160, "Record of Health Cost-Share of Cost-Medicaid Program" (see 471-000-79). For further information, the provider may contact the client's local office.

3-002.06 Inquiry on Status of Claims: For questions regarding claim status, providers may contact Department staff as directed in the claim submission instructions in the appendix to this Title or the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277) (see standard Electronic Transaction Instructions at 471-000-50). Providers may direct questions regarding regulations to the Medicaid Division.

3-002.07 Adjustments to Payment Reductions or Disallowances: Providers are restricted to a maximum time limitation of 90 days to request an adjustment to a claim that has been paid with a portion reduced or disallowed, or a claim that has been disallowed in total, unless documentation of extenuating circumstances is submitted to the Medicaid Division. The 90-day limitation begins with the payment date of the paper remittance advice (Form MCP-248) or with the payment date of the electronic remittance advice (ASC X12N 835).

3-002.08 Refunds

3-002.08A Refunds Requested by the Department: When the Department requests a refund of all or part of a paid claim, the provider is allowed 30 days to refund the amount requested, to show that the refund has already been made, or to document why the refund request is in error or appeal. The provider's failure to respond within 30 days shall be cause for the Department



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to recoup from future provider payments until the situation is resolved or to sanction the provider. The refund request shall constitute notice of the sanction to recoup from future payments. For refunds due to third party resources, see 471 NAC 3-004.10.

Note: *NE-POP providers may be requested to void claims through the NE-POP system instead of submitting checks.*

3-002.08B Third Party Liability Refunds: Whenever third party liability payments are received after a claim has been submitted to the Department, the provider shall refund the Department within 30 days. The refund must be accompanied by a copy of the documentation, such as the explanation of benefits or electronic coordination of benefits.

3-002.08C Provider Refunds to the Department: Providers have the responsibility to review all payments to ensure that no overpayments have been received. The provider shall refund all overpayments to the Department within 30 days of identifying the overpayment.

3-002.09 Claim Reports: These claim reports are issued weekly.

3-002.09A Remittance Advice: Remittance advice for payment of approved services is issued electronically using the standard Health Care Claim Payment/Advice transaction (ASC X12N 835) or on paper with Form MCP248 Remittance Advice (see 471-000-85).

3-002.09B Refund Request: A request for refund is issued electronically or on paper with Form MCP248 Refund Request.

3-002.09C Rejected Claims, Deleted Claims, and Denied Adjustments: Rejected claims, deleted claims, and denied adjustments are reported on Form MCP524, Electronic Claims Activities Report.

3-002.10 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

“Reopening” means an action taken by the Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken –

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. At any time fraud or abuse is suspected.

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A provider has no right to a hearing on a finding by the Director that a reopening or correction of a determination or decision is not warranted.

3-002.11 Billing the Client: Providers participating in NMAP agree to accept NMAP's payment as payment in full. The provider shall not bill the client for Medicaid coverable services if the claim is denied by the Department for lack of medical necessity or for failure to follow a procedural requirement (such as prior authorization, claim submission instructions, timely claims filing limits, etc.). The provider shall not bill the client for services covered by NMAP. It is not a violation of NMAP's regulations for the provider to bill the client for services not covered by NMAP. It is not a violation for a provider to bill the client for services when it is determined that the client has received money from a third party resource and that money was designated to pay medical bills. See 471 NAC 3-004.10B, 3-004.05, and 3-004.05F.

If the client agrees in advance in writing to pay for the non-covered service, the provider may bill the client.

The provider has the responsibility to verify the client's eligibility for Medicaid and any limitations, such as lock-in or managed care, that apply to a specific client. It is the provider's responsibility to be aware of requirements for medical necessity, prior authorization, referral management, etc.

3-002.12 Section 1122 Sanctions: When the Department of Health and Human Services imposes a sanction under section 1122 of the Social Security Act and instructs the Department to withhold or recoup the federal share of the capital expenditure, the Department shall withhold the federal and the state share of the capital expenditure.

3-002.13 Disclosure of Information: See 465 NAC 2-005.02.

3-003 Billing Requirements

3-003.01 Claims Submission: Providers shall submit claims for payment for medical services on the appropriate Medicaid billing forms attached and incorporated into these rules or the appropriate ASC X12N health care claim format for electronic transactions.

3-003.01A Institutional Services: Claims for the following services must be submitted by using the paper Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49.):

1. Ambulatory Room & Board; 6. Hospital;
2. Assisted Living Facilities; 7. Hospital-Based Ambulance;
3. Dialysis; 8. ICF/MR's; and
4. Home Health; 9. Nursing Facilities*.
5. Rural Health Clinic;

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* Form MC-4, Long Term Care Turnaround may be used for nursing facility services instead of Form CMS-1450.

3-003.01B Practitioner Services: Claims for the following services must be submitted by using the paper Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49.):

1. Ambulatory Surgical Center
2. Durable Medical Equipment and Supplies
3. Federally Qualified Health Center
4. Licensed Practitioner (to submit claims for Dental services, see 471 NAC 3-003.01D)
5. Medical Transportation*
6. Non-Hospital-Based Ambulance
7. Non-Rural Health Clinic
8. Personal Care Aide**; and
9. Private Duty Nursing***

* Form MS-65 must be used for paper submission of claims for Medical Transportation Services (see 471-000-63). Form MS-66 must be used for paper submission of claims for mental health transportation services.

** Form MC-82 must be used for paper submission of claims for Personal Care Aide Services (see 471-000-60).

*** Form MC-82N must be used for paper submission of claims for Private Duty Nursing services (see 471-000-59).

*** Form MC-82-AD must be used for paper submission of claims for private duty nursing or personal care aide services provided in adult day care centers.

3-003.01C Retail Pharmacy Services: Claims must be submitted electronically via the Nebraska Point of Purchase (NE POP) system, using the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard transaction.

3-003.01D Dental Services: Claims must be submitted by paper using the American Dental Association (ADA) Dental Claim Form or the standard electronic Health Care Claim: Dental Transaction (ASC X12N 837). For instructions on claim submission, see the Claim Submission Table in the appendix at 471-000-49.

3-003.02 Claim Certification: The submission of the claim form by the provider, the provider's authorized representative, or the provider's billing agent on behalf of an approved provider certifies that:

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1. The services were medically indicated and necessary to the health of the patient, and were personally rendered by the provider, or under the provider's direction;
2. The services were provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973;
3. The amounts claimed are in compliance with the Department's policies, and no additional charge has been or will be made;
4. The information on the claim is true, accurate, and complete;
5. Each service is documented in the provider's files, and documentation is available to the Department, the federal Department of HHS, and state and federal fraud and abuse units; and
6. The provider understands that payment and resolution of this claim will be made from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

3-003.02A Paper Submission: The provider, the provider's authorized representative, or the provider's billing agent on behalf of an approved provider must sign the paper Medicaid billing forms that contain signature fields. Computer generated signatures are accepted and must be the signature of the service rendering provider, not the clinic or corporation. When a computer-encoded document is used as the Medicaid billing mechanism, the Department may request the provider's source input document from the provider for input verification and signature requirements. The signature constitutes certification as required by 471 NAC 3-003.02.

3-003.02B Electronic Submission: The submission of any electronic claim by the provider, the provider's authorization representative, or the provider's billing agent on behalf of an approved provider constitutes certification as required by 471 NAC 3-003.02.

3-003.03 Claims for Prolonged Care: When medical care is required for a prolonged period, such as nursing home care, extended hospital care, home health agency care, or other continuous service, the Department recommends that the provider submit claims for payment at intervals of not less than one month, so that payment may be kept current.

3-003.04 Electronic Claims and Computer-Encoded Claim Documentation: The provider shall allow the authorized representatives of the federal Department of HHS, the Department, and state and federal fraud and abuse units to review and audit the provider's or the provider's billing agent's or clearinghouse's data processing procedures and supportive software documentation involved in the production of the computer-encoded claims or electronic claims submitted to

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the Department. The provider has agreed to allow the Department and its authorized representatives access to its records under the provider agreement.

3-004 Third Party Resources (TPR): All third party resources available to a Medicaid client must be utilized for all or part of their medical costs before Medicaid. Third party resources (TPR) are any individual, entity, or program that is, or may be, contractually or legally liable to pay all or part of the cost of any medical services furnished to a client. Third party resources include, but are not limited to –

1. Private health insurance;
2. Casualty insurance, including medical payment provisions;
3. Employment-related group health insurance;
4. Group health plans defined under section 607(1) of ERISA;
5. Medicare Part A and/or Part B;
6. Medicare Part C (Medicare Advantage plans);
7. Medicare Part D;
8. Medical support from non-custodial parents (court or administrative ordered) (see 471 NAC 3-004.08);
9. Excess income/share of cost (see 471 NAC 3-001.05);
10. Workers' compensation;
11. Other federal programs (unless excluded by statute, such as Indian Health Services programs and Migrant Health programs, and Title V, Maternal Child Health Program);
12. Liable third parties who are not insurance carriers;
13. Medical payments provisions of automobile and commercial insurance policies; and
14. Any other party contractually or legally liable to pay medical expenses.

The Nebraska Chronic Renal Disease Program and the Medically Handicapped Children's Program are not included as TPR. Medicaid payment is made only after all third party resources have been exhausted or met their legal contractual or legal obligations to pay. Medicaid is the payor of last resort.

3-004.01 Definitions: The Nebraska Medical Assistance Program (NMAP) uses the following definitions in relation to third party resources:

Adjudicate: To determine whether a claim or adjustment is to be paid or denied.

Balance Billing: Billing NMAP or client for remaining amount left after a provider has agreed to accept a lesser amount from the primary payor as payment in full. Balance billing is prohibited.

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Casualty Insurer: An insurance policy that pays for medical care as a result of an accident, incident, injury, disability, or disease; for example, automobile insurance, homeowners insurance, commercial liability insurance, product liability insurance, workers compensation, etc.

Client Assignment of Rights: The client's action to assign to the Department his/her rights (and the rights of any other eligible individuals on whose behalf she/he has legal authority under state law to assign such rights) to medical support and to payment for medical care from any third party resource (except Part A and B of Medicare). Assignment of rights is accomplished by signing the Medicaid application.

Commercial/Cost-Share Co-payment: Fixed payment amounts, as determined by the insurer (including Medicare Advantage plans), that an individual must pay to access services.

Cost Avoidance: A method of adjudicating claims as payor of last resort in order to utilize all third party resources before Medicaid payment can be made.

Denial: Non-payment of benefits by a third party resource. See 471 NAC 3-004.06D1.

Excess Income/Share of Cost: The amount of the client's income that must be obligated or paid for medical care before Medicaid payment can be made.

Health Insurer: Any group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act (ERISA) of 1974 (amended in 1993), an entity offering a service benefit plan, or a health maintenance organization (HMO).

HMO Plan: Health Maintenance Organization - A type of managed care health plan that provides health care in return for a fixed payment from a subscriber or their employer with medical care being restricted to network physicians and a referral being necessary to utilize providers outside the network.

Lien: A method for physicians, nurses, and hospitals to protect the value of medical services by filing legal notice of right to payment pursuant to Neb.Rev. Stat. Section 52-401.

Medical Support: The obligation of a non-custodial parent to provide health insurance and/or pay for medical care ordered by a court or administrative body established under state law.

Medicare Advantage Plan: Medicare C - Coordinated care plans that meet Medicare C (Medicare Advantage plan) standards, including health maintenance organizations (HMO) (with or without point of service options), Provider Sponsored Organizations (PSOs) and Preferred Providers Organizations (PPOs), religious fraternal benefits plans, and other coordinated care plans.



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Persons eligible for Medicare Part A and Part B may choose to enroll in a Medicare Advantage Plan instead of the traditional Medicare fee-for-service program. Part B only enrollees are ineligible.

Medicare/Medicaid: Persons dually eligible for Medicare and Medicaid during the same period of time.

Medicare Part A: A federal program, created by the Social Security Act of 1965, to provide coverage of hospital, skilled nursing and certain other services for Medicare beneficiaries.

Medicare Part B: A federal program, created by the Social Security Act of 1965, to provide coverage of practitioner, durable medical equipment, supplies and certain other services for Medicare beneficiaries.

Co-insurance: A dollar amount, usually expressed as a percentage, for a covered service that is not paid by the primary insurer, that is the financial responsibility of the client or other payer on behalf of the client. (For example, for Medicare Part B covered services, Medicare pays 80% of the Medicare allowable and the remaining 20% is the co-insurance amount).

Deductible: A dollar amount, other than a premium, that a client, or other payer on behalf of the client, must pay before any covered service is paid for by the insurer. (For example, the standard Medicare Part D deductible for calendar year 2006 is \$250).

Coverage Gap: for Medicare Part D, the cost of Part D drugs for which there is no coverage, also known as the "doughnut hole". (For calendar year 2006, for beneficiaries that do not qualify for the low income subsidy, the coverage gap is \$2,250 to \$5,100 or \$2,850).

Premium: The cost of purchasing insurance, Medicare or other health insurance coverage, which may be a monthly or annual dollar amount. (For example, the Medicare Part B premium for calendar year 2005 is \$78.20 per month).

Medicare Part D: A federal program, also known as the Medicare prescription drug benefit, that was created by the Medicare Modernization Act of 2003 (P.L. 108-173). This voluntary program provides coverage of certain drugs, classes of drugs or therapeutic categories of drugs and certain medical supplies or equipment for all Medicare beneficiaries, including those beneficiaries that are also eligible for Medicaid (dual-eligibles). Clients who are dual eligibles are automatically enrolled in Part D.

Medicare Part D Plan: An entity, approved by the Centers for Medicare and Medicaid Services, to provide coverage of Medicare Part D drugs and certain medical supplies related to the administration of insulin for Medicare beneficiaries under the Medicare Modernization Act of 2003 (P.L. 108-173).



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Medicare Part D Drug: Any drug, class of drugs or therapeutic category of drugs that is not a Medicare Part D Excluded drug (see definition of Medicare Part D Excluded drug below), regardless of formulary, prior approval or tiering status by the Part D Plan.

Medicare Part D Excluded Drug: Any drug, class of drugs or therapeutic category of drugs that is specifically excluded from coverage under the Medicare Modernization Act of 2003 (P.L. 108-173) and amendments to that act, and/or as defined by federal regulations implementing the Medicare Modernization Act (for example, cough and cold preparations).

Medicare Part D Covered Supplies or Equipment: Insulin syringes, needles, alcohol swabs, gauze and other products related to the administration of insulin that are covered by Medicare Part D Plans.

Non-Custodial Parent: Parent who does not reside with a child but has a legal responsibility to provide court or administrative ordered medical support for the child.

Pay and Chase: A recovery method in which Medicaid pays the total amount allowed under NMAP and then seeks to recover from liable third party resources.

Private Insurer: This includes –

1. Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-related and indemnity contracts);
2. Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis and treatment of an injury, disease, or disability; and
3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments for services, including self-insured and self-funded plans (under section 607(1) of ERISA).

PPO Plan: Preferred Provider Organization - Fee for service plan with an incentive to use network providers to provide care for the plan's subscribers. Patients may see physicians outside the network but at reduced payment rate. A co-payment may be required on certain services.

PSO Plan: Provider Sponsored Organization - Public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial portion of health care items and services directly through providers or affiliated groups of providers. Affiliated providers share, directly or indirectly, substantial financial risk, and have at least a majority financial interest in the PSO.



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Remittance Advice: The third party plan's statement of payment for services. When billing Medicaid, this statement may be provided as a paper or electronic remittance advice, and must include the following information: the insurance company name, patient name, dates of service, charges, and amount paid. If charges were denied by insurance, the portion of the remittance advice showing the denial reason must be included.

Subrogation: Right of the state to stand in place of the client in collection of third party resources.

3-004.02 Availability of Third Party Resource Information: The Coordination of Benefits/Third Party Liability (COB/TPL) Unit of the Department of Health and Human Services Finance and Support maintains all known current health insurance, casualty insurance, and/or Medicare coverage on the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124). Providers may also obtain this information using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). If the provider becomes aware of any additional third party resources, the provider shall contact the COB/TPL Unit and report the new sources.

3-004.02A Request for Release of Patient Account Information: To alert the Department to potential TPR, the provider shall notify the COB/TPL Unit if a provider receives a request for an itemized bill or a request for the balance of a bill from the client, an attorney, an insurance company, or employer. This does not include routine billing information requests to process insurance or Medicare. The provider may release the information in accordance with the provider's standard office practice.

3-004.03 Payor of Last Resort: Medicaid clients who have third party resources must exhaust these resources before Medicaid considers payment for any services. Medicaid shall not pay for medical services as a primary payor if a third party resource is contractually or legally obligated to pay for the service.

Providers shall bill all third party resources and/or the client (when there is an excess income/share of cost obligation) for services provided to the client, except for waiver claims (see 471 NAC 3-004.03A). Providers shall submit all charges and Medicare covered services provided to Medicare/Medicaid clients to Medicare plus any Medicare supplement plans for resolution prior to billing Medicaid. Medicaid is the payor of last resort.

3-004.03A Waiver Claims: Certain services, defined as "waiver claims," are an exception to the requirement of 471 NAC 3-004.03. Providers may submit these claims to Medicaid before filing for TPR; NMAP pays these claims and COB staff initiate recovery activities for any TPR. This does not prohibit the provider from billing the TPR before billing Medicaid. In these situations, the provider does not bill Medicaid until the claim is resolved.

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Waiver claims, for health insurance purposes, are claims for which the Department has applied and received a “cost avoidance” waiver from CMS or claims that are mandated to have cost avoidance waived under 42 CFR 433.139 (preventive pediatrics, prenatal services, medical support from “uncooperative” non-custodial parents).

3-004.03B Services Not Covered by Medicare: NMAP may cover services within the scope of NMAP that are not covered by Medicare. NMAP shall not cover any Medicare Part D Drug or Medicare Part D covered supply or equipment even if coverage is denied by the Medicare Part D Plan. For services never covered by Medicare, documentation of the Medicare denial is not required. For NMAP covered services, refer to individual 471 NAC chapters.

3-004.03C Provider Practices: It is the provider’s responsibility to protect the value of their services through the use of sound business practices. Providers can best protect themselves by adopting procedures which –

1. Seek assignment of proceeds of health insurance policies;
2. Seek assignment of the provider’s rights to institute legal recovery of medical expenses; or
3. Place liens against the outcome of third party resources (Exception: Waiver claims or professionals unable to file liens).

3-004.04 Medicare Part A & B Deductible and Co-insurance: Medicaid pays the deductible and Co-insurance for Medicare-covered services. The Department accepts Medicare’s utilization review and payment decisions for Medicare allowable fees. The amount received from Medicare for Medicare-covered services and other TPR and/or Medicaid for deductible and/or Co-insurance shall not exceed Medicare allowable amount. (See billing instructions 471-000-70.)

3-004.04A Medicare Part D Monthly Premium, Deductible, Co-Insurance and Coverage Gaps: Medicaid does not pay the premium, deductible, co-insurance or coverage gaps for Medicare Part D.

3-004.04B Medicare Part A Co-insurance for Nursing Facility Services:

For nursing facility services covered under Medicare Part A, Medicaid payments are limited to rates and payments according to the following method:

1. If the Medicare payment amount for a claim exceeds or equals the Medicaid rate or payment for that claim, Medicaid reimbursement will be zero (0).
2. If the Medicaid rates and payments for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:
 - a. The difference between the Medicaid rates and payments minus the Medicare payment amount; or
 - b. The Medicare Co-insurance and deductible, if any, for the claim.

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3-004.05 Provider Payment in Full: Medicaid payment is the lower of the provider's usual and customary charge or the Medicaid allowable less all third party payment. When a claim is submitted to Medicaid with a payment from a third party resource, the provider is considered paid in full when payment from the third parties and/or Medicaid equals or exceeds the Medicaid allowable amount. The provider may only bill the client for a Medicaid noncovered service, or Medicaid co-payment fees, where applicable, or if the client has received payment from the TPR.

3-004.05A Medicare Part A & Part B: NMAP payment of Medicare Co-insurance and deductible constitutes payment in full. The provider shall not balance bill.

3-004.05B Medicare Advantage: NMAP payment of Medicare Advantage Co-insurance and deductible constitutes payment in full to the provider. The provider shall not balance bill.

3-004.05C Medicare Part D: NMAP does not pay premiums, deductible, co-insurance or coverage gaps for Medicare Part D.

3-004.05D Medicare Waiver of Liability: When a Medicare/Medicaid client signs a Medicare Waiver of Liability and Medicare denies the claim as "not reasonable and necessary," NMAP will not pay the claim.

3-004.05E Use of Contracts by Medicare/Medicaid Beneficiaries: If providers negotiate private contracts with Medicare/Medicaid beneficiaries for which no claim is to be submitted to Medicare and for which the provider receives no reimbursement from Medicare directly, neither Medicare nor Medicaid would cover the services provided under the private contract.

3-004.05F Casualty Settlements With a Third Party Resource: When a provider enters into an agreement with a Medicaid client or a representative of the client to accept less than billed charges, the provider is considered paid in full. No further payment is due from either the client or NMAP.

3-004.05G Provider's Failure to Cooperate in Securing Third Party Payment: The provider's failure to file necessary claims for TPR (except waiver claims) or to cooperate in securing payments by other third party resources are grounds for denial of the claims. If NMAP denies claims for these services, the client cannot be billed unless the payment went to the client.

3-004.06 Filing Claims with TPR

3-004.06A Waiver of Cooperation for Good Cause: With respect to obtaining medical care support and payments or identifying and providing information to assist the State in pursuing liable third parties for a child for whom the individual can legally assign rights, the Department must find that cooperation is not in the best interests of the individual or the person to whom Medicaid is being furnished because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person (see 466 NAC 1-006.04).

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3-004.06B Timely Filing of Claims with Health Insurance: Providers shall first submit all claims to third party resources. To secure a provider's right to Medicaid consideration for payment, a claim must be filed within 12 months from service date even if the TPR has not been resolved. If the provider fails to submit a claim or fails to contact the COB Unit within 12 months from the date of service, NMAP will not pay the claim.

If the provider filed a claim with NMAP within 12 months of the date of service and received a Medicaid denial due to the existence of a third party resource, the provider is allowed up to 12 months from the original receipt date of the Medicaid claim to resolve the third party resource. The provider shall submit the claim to NMAP within six months of the date on the insurance or Medicare remittance advice no later than 12 months from the original receipt date of the Medicaid claim.

3-004.06C Timely Filing of Claims with Casualty Insurance: Providers must submit claims within 24 months of the date of service. In some casualty third party situations, the Department recognizes that it may take longer than 24 months to resolve the third party obligation. In these situations, the Department can make payment beyond the 24 months if the provider can document that action was taken to obtain payment from the third party. If a provider has received a denial from NMAP due to the existence of casualty insurance coverage and the provider has sought payment from the third party, then the provider can request the Department to reconsider payment if the provider has waited 24 months and the third party has not paid the provider. If the provider has filed a lien, then the provider shall release its lien upon receipt of payment from NMAP. These situations are reviewed on a case by case basis.

3-004.06D Filing Medicaid Claims After Resolving Third Party Resources: Providers shall bill NMAP only when all third party resources have failed to cover the service or when a portion of the cost of the service has been paid. The provider must submit the third party documentation (such as the remittance advice, letter of denial, letter from attorney, or copy of check) with each claim submitted to the Department. The dates of service on the third party documentation must match the dates of service on each claim.

When billing NMAP, the provider shall bill the usual and customary charge for each service. The provider shall not submit a claim showing only the Medicaid allowable amount or the difference between the Medicaid allowable amount and the amount of the third party payment.

If after the provider has submitted a claim with the third party resource documentation and NMAP has adjudicated the claim for payment and the provider wishes to request an adjustment, the provider must submit the adjustment request within 90 days from the payment date on the Remittance Advice.



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3-004.06D1 TPR Denials

3-004.06D1a Health Insurance Denials: NMAP will recognize and consider payment on claims the health insurance has denied with a valid health insurance denial. A valid health insurance denial may include, but is not limited to, the following reasons:

1. Deductible was applied to dates of service on this claim;
2. Coverage was not in effect for this client on dates of service;
3. Client was never covered;
4. Annual or lifetime maximum allowable for the services has been exhausted during or prior to dates of service; or
5. Non-covered service based on policy exclusions.

3-004.06D1b Medicare Denials: NMAP will recognize and consider payment on claims Medicare has denied when the claim is submitted with a valid Medicare denial. A valid Medicare denial may include, but is not limited to, the following reasons:

1. Coverage was not in effect for this client on dates of service;
2. Client was never covered by Medicare;
3. Non-covered procedure; or
4. Item or service is never covered by Medicare.

NMAP may not consider payment for services that have been denied by Medicare for lack of medical necessity.

3-004.06D1c Casualty Insurance Denials: NMAP will recognize and consider payment on claims involving casualty coverage denial, when the claim is submitted with a valid casualty denial. A valid casualty insurance denial may include, but is not limited to, the following reasons:

1. Services not related to the incident;
2. Coverage not in effect; or
3. Coverage limits exhausted for all coverage types available and with all insurance carriers obligated.

The insurer's statement that payment cannot be made at this time due to a pending liability determination or litigation is not a valid denial. Information is provided on Form MCP 575, "Casualty Insurance Information Sheet."

3-004.06D2 Filing Electronic Claims with Third Party Resources: Medicaid will accept electronic claims when third party resources (health insurance and/or Medicare coverage) are available. The health insurance and/or Medicare documentation is required. (See 471-000-103.)



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3-004.06D2a Automatic Transfer of Claims From Medicare:

NMAP accepts Medicare crossover claims directly from Medicare's fiscal intermediaries and will pay the deductible and Co-insurance when no additional third party resource is identified. Claims received from Medicare must include Medicare supplemental insurance coordination of benefits/remittance advice documentation, if applicable.

3-004.06E Third Party Resource Reversal of Payment to Provider: If a provider filed a claim with a third party resource and received payment in full, and thus did not bill Medicaid, and the third party resource reverses its determination after 12 months from the date of service, the provider may bill NMAP for the services. The provider shall bill NMAP within 60 days from the date on the third party reversal document and refund. The provider shall submit documentation of the reversal with the claim. The claim may be considered for payment by NMAP only if the date of service is no more than 24 months from the date of receipt of claim.

3-004.06F Prior Authorization and Third Party Resources: The provider shall resolve all third party resources before Medicaid can consider paying a claim even when Medicaid prior authorization has been given.

3-004.06G Client's Medicaid Eligibility and Third Party Resources: The provider shall resolve all third party resources before Medicaid can consider paying a claim even though the client is eligible for Medicaid. (Exception: Waiver claims - see 471 NAC 3-004.03A.) A client's eligibility for NMAP does not guarantee payment of a claim.

3-004.07 Long Term Care Insurance Policies: A long term care indemnity policy is considered a health insurance policy when the policy –

1. Allows assignment of benefits; and
2. Covers medical care based on specified criteria.

Long Term Care insurance which meets this criteria is not considered income for eligibility determination.

Because nursing facility claims are included in the category of "waiver claims," NMAP will pay these claims at the specific per diem for the client less any excess income/share of cost the client is obligated to pay the provider for the monthly services. The COB Unit will seek recovery on all of these policies. Because the claims have been paid, the provider shall not bill the insurer. The provider shall assist the COB Unit in obtaining reimbursement from these policies by furnishing any medical documentation the insurer requests.

A provider may choose to bill the long term care insurance; in these situations, the provider does not bill Medicaid.

If the provider or the client receives a payment directly from the insurer, the payment shall be sent to the COB/TPL Unit.



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Whenever the Department receives any payments from long term care insurance which exceed what Medicaid has paid toward the care of the client, the Department shall apply the excess to any Medicaid expenditure for that Medicaid client even if the expenditure was not covered by the third party. The application of the excess TPL payment is not limited to a particular Medicaid service and can be applied to any claims for that Medicaid client paid by Medicaid. After the excess TPL payment has been applied to all claims, any remaining amount shall be paid to the client.

3-004.08 Medical Support from Non-Custodial Parents: When children with a non-custodial parent become Medicaid eligible, medical support is court ordered in compliance with Omnibus Budget Reconciliation Act 1993 (OBRA '93). The County Attorney's staff or Child Support Enforcement staff shall notify the COB/TPL Unit of any health insurance coverage and/or Medical Support Court Orders obtained for a child who is eligible for Medicaid. When a non-custodial parent is ordered by the court to furnish health insurance and/or make payment for medical services the provider may bill Medicaid for the services if the provider has not received payment from the health insurer or non-custodial parent within 30 days of the date of service. Medicaid shall pay the claims and the COB/TPL Unit shall seek recovery from the health insurer or non-custodial parent.

To determine whether a court order exists, the provider may contact the COB/TPL Unit. The provider is not required to continue to seek payment from the health insurer or non-custodial parent before billing Medicaid when there is court-ordered medical support.

Non-custodial parent medical support court orders may include an obligation by the non-custodial parent to pay a percentage of medical expenses after the health insurer has made payment. The provider is not required to seek payment from the non-custodial parent in these cases. If the provider receives a payment from a non-custodial parent, the provider shall indicate this amount and the amount received from the health insurer as a prior payment or amount paid on the claim submitted to Medicaid. The provider shall submit with the claim a copy of the documentation showing the non-custodial parent made the payment. If the provider receives payment from the non-custodial parent after Medicaid has paid the claim, the provider shall refund Medicaid according to 471 NAC 3-004.10A.

3-004.08A Health Insurer Obligation When Non-Custodial Parent Has

Medical Support Court Order: A health insurer may not deny a child insurance coverage if the non-custodial parent has a court or administrative order for medical support. An insurer shall provide custodial parents information to file claims; allow the custodial parent or provider to file claims; and pay claims to the custodial parent, provider, or the Department, as required by Neb.Rev.Stat. Section 44-3,149. If the provider receives a denial of insurance coverage for any of these reasons from an insurer and the client is a child, the provider shall contact the COB/TPL Unit.

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3-004.09 Provider Refunds to the Department: When a provider receives payment from a third party resource on a claim previously paid by NMAP, the provider shall submit a refund to the Department. The provider shall include the third party documentation, such as a remittance advice or coordination of benefits, letter from an attorney or copy of a check, with the refund. If the payment from the third party resource equals or exceeds the Medicaid payment on the claim, the total Medicaid payment must be refunded to the Department. If the payment from the third party resource is less than the Medicaid payment on the claim, the total third party payment must be refunded to the Department.

Note: *The Department may request NE Point of Purchase (NE-POP) pharmacy providers to void claims through the NE-POP system instead of submitting refunds.*

If, after NMAP has paid, a provider learns of a third party resource which would have paid more for the service than NMAP's allowable, in cases where health insurance is the third party resource, the provider may supply the COB Unit with the third party resource information, refund the Department the full NMAP payment, and then seek recovery from the third party resource. If a Medicaid client becomes retroactively eligible for Medicare, the provider shall refund the Department the full NMAP payment and seek reimbursement from Medicare for payment unless Medicare filing time limits for dates of service on the claims have been exhausted. In cases where casualty insurance is the third party resource, the provider shall not refund Medicaid's payment and then seek recovery from a third party resource, unless the refund is requested by the Department.

3-004.09A Department Requests for Refunds: When the Department receives information that the provider has received a third party resource payment on a Medicaid paid claim, the Department shall notify the provider that a refund is due to the Department. The provider is allowed 30 days to submit a refund check, show that the refund has already been made, document that the refund request is in error, or appeal. Failure to comply with this request within 30 days shall be cause for the Department to withhold future provider payments until the situation is resolved or impose sanctions on the provider. The refund request shall constitute notice of sanction.

3-004.10 Client Rights and Responsibilities

3-004.10A Client's Rights: A provider shall not refuse to furnish services to an individual who is eligible for Medicaid because of a third party's potential liability for payment of service.

3-004.10B Client's Failure to Cooperate: A Medicaid client has the obligation to assist the provider and the Department in obtaining payment from all

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available third party resources. This may include complying with any requests from the insurer for additional information, ensuring that the provider or the Department receives remittance advice/coordination of benefits and/or payments from the insurer, or appearing in court in litigation situations. If the client fails to cooperate with the provider in securing third party resources, the provider may contact the COB/TPL Unit. Failure by the client to cooperate may cause the client to lose his/her Medicaid eligibility. The client will be responsible for charges on the denied services.

3-004.10C Client Responsibility When Enrolled in HMO or PPO Plan:

Clients are required to utilize the services provided through and to obtain all necessary prerequisites as set out by the HMO or PPO plan (e.g., obtaining prior authorizations, using network providers, etc.). Failure to do so is considered lack of cooperation and will result in loss of Medicaid eligibility. The client is responsible for the charges on the denied services.

3-004.10D Client Responsibility When Health Insurance Premiums are Paid by the Department:

If the Department determines it is cost effective to pay the premiums for a Medicaid eligible client to maintain their current commercial insurance coverage, the client shall follow any pre-authorization or referral provisions of the plan or utilization of specific providers in the network. Claims denied by TPR because client did not utilize a network provider or obtain necessary authorizations or referrals will not be paid by Medicaid. The client will be responsible for the charges on the denied services.

3-004.10E Client Responsibility When Client Chooses to Enroll in Medicare Advantage (Medicare C) Plans:

Medicaid will not pay claims denied by Medicare for Medicaid clients enrolled in Medicare Advantage plans who move out of the service area without complying with notification requirements. The client will be responsible for the charges on the denied services.

Claims denied by the Medicare Advantage plan because the client did not utilize a network provider or obtain necessary authorizations or referrals will not be paid by Medicaid.

3-004.11 Nebraska Medicaid Managed Care and Health Third Party Resources:

Medicaid clients with Medicare or private health insurance determined to be "qualified coverage" (as indicated in 482 NAC 2-000 ff. such as full commercial coverage, HMO plans, or PPO plans) are excluded from mandatory participation in the Nebraska Health Connection. If a client becomes enrolled in both NHC and Medicare and/or a private insurance plan at the same time, the provider should contact the NHC plan on coordination of benefits issues.

The provider shall obtain prior authorization and/or referrals from all third party resources to avoid nonpayment. If the provider has difficulty obtaining third party payment or denials from the commercial plan and the policyholder is a non-custodial parent, the provider may contact COB staff for review on a case-by-case basis.

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If the provider receives reimbursement from commercial insurance and/or Medicare while the client is enrolled in an NHC plan, the provider shall refund the NHC plan. Medicaid is refunded when the service was paid "fee for service" by NMAP as an exception (as indicated in 482 NAC 2-000).

3-004.12 Coordination of Benefits with Health Plans and Self-funded Insurers:

These regulations implement Neb. Rev. Stat. §§ 68-926 to 68-933 governing coordination of benefits between licensed and self-funded insurers and the Nebraska Medicaid Program.

3-004.12A Definitions:

Coordinate benefits means:

1. Provide to the Department of Health and Human Services information regarding the licensed insurer's or self-funded insurer's existing coverage for an individual who is eligible for a state benefit program; and
2. Meet payment obligations to providers of health care services on behalf of Medicaid clients.

Coverage information, for other than limited benefit policies, means health information possessed by a licensed insurer or self-funded insurer that is limited to the following information about an individual:

1. Eligibility for coverage under a health plan;
2. Coverage of health care under the health plan; or
3. Benefits and payments associated with the health plan.

Coverage information for limited benefit policies means whether an individual has coverage, and, if so, a description of that coverage.

Department means the Department of Health and Human Services.

Health plan means any policy of insurance issued by a licensed insurer or any employee benefit plan offered by a self-funded insurer that provides for payment to or on behalf of an individual as a result of an illness, disability, or injury or change in a health condition.

Individual means a person covered by a state benefit program, including Medicaid, or a person applying for coverage under a state benefit program.

Licensed insurer means any insurer, except a self-funded insurer, including a fraternal benefit society, producer, or other person licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of Nebraska.

Limited benefit policy means a policy of insurance issued by a licensed insurer that consists only of one or more, or any combination of the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;



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2. Coverage for specified disease or illness; or
3. Hospital indemnity or other fixed indemnity insurance.

Medicaid means the medical assistance program established under Neb. Rev. Stat. §§ 68-901 to 68-949.

Self-funded insurer means any employer or union who provides a self-funded employee benefit plan.

3-004.12B Coverage Information Requests: The Department may request coverage information from a licensed insurer or a self-funded insurer about a specific individual without the individual's authorization to:

1. Determine an individual's eligibility for state benefit programs, including Medicaid; or
2. Coordinate benefits with state benefit programs.

The Department will specify the individual recipients for whom information is being requested.

3-004.12B1 Response to Requests: Self-funded insurers and licensed insurers must respond within 30 days of receipt of any request for coverage information from the Department, sent by first class mail. The information must be provided within thirty days after the date of the request unless good cause is shown.

3-004.12C Failure to Acknowledge and Respond to Coverage Information Requests

3-004.12C1 If a licensed insurer fails to acknowledge and respond to a request from the Department for coverage information about an individual, the Department will refer the insurer's failure to respond to the Department of Insurance under the Unfair Insurance Claims Settlement Practices Act.

3-004.12C2 If a self-funded insurer fails to acknowledge and respond to a request from the Department for coverage information about an individual, the Department may find this a violation of the requirements of 471 NAC 3-004.12B and impose a civil money penalty.

3-004.12C3 Civil Money Penalty: The Department may impose and collect a civil money penalty on a self-funded insurer who fails to respond to a coverage information request under 471 NAC 3-004.12B if the Department finds that the self-funded insurer:

1. Committed the violation flagrantly and in conscious disregard of the requirements; or
2. Has committed violations with such frequency as to indicate a general business practice to engage in that type of conduct.

3-004.12C3a The Department may impose a civil money penalty of no more than \$1,000 for each violation, not to exceed an aggregate penalty



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of \$30,000, unless the violation by the self-funded insurer was committed flagrantly and in conscious disregard of 471 NAC

3-004.12B in which case the penalty will not be more than \$15,000 for each violation, not to exceed an aggregate penalty of \$150,000.

3-004.12C3b To assess a penalty, the Department will:

1. Provide written notice of the violation to the self-funded insurer. The notice will specify:
 - a. The total amount of the civil money penalty;
 - b. The evidence on which the civil money penalty is based;
 - c. That the self-funded insurer may request, in writing, a hearing to contest the assessment of a civil money penalty in accordance with 465 NAC 6-000; and
 - d. That an unpaid civil money penalty constitutes a debt to the State of Nebraska which may be collected in the manner of a lien, foreclosure, or sued for and recovered in a proper form of action in the name of the state in the District Court of the county in which the violator resides or owns property; and
2. Send by certified mail, a written notice of the civil money penalty to the last known address of the person to whom the penalty is assessed.

3-004.12C3c The Department is authorized to recover all amounts paid or to be paid to state benefit programs as a result of failure to coordinate benefits by a licensed insurer or a self-funded insurer.

3-004.12C3d The Department will submit all money collected as a civil penalty under 471 NAC 3-004.12C3 to the State Treasurer, for distribution pursuant to Article VII, Section 5 of the Constitution of Nebraska.

3-004.12D Hearing: A licensed insurer or a self-funded insurer's request for a hearing to appeal an action by the Department must comply with 465 NAC 6-000.

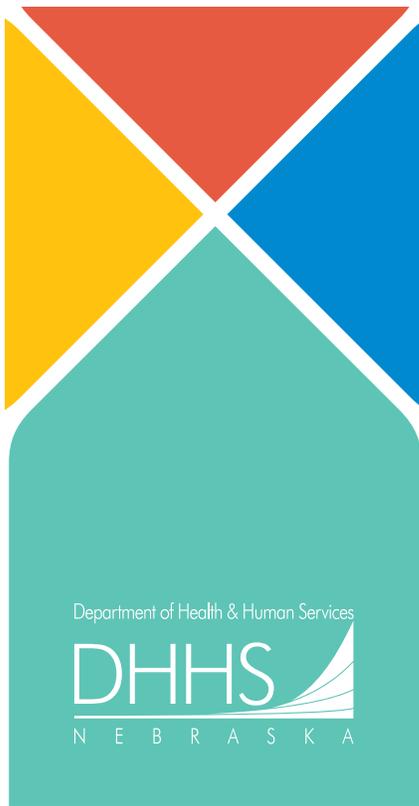
3-005 Prior Authorization: The Department is responsible for ensuring the appropriate expenditure of NMAP funds for medically necessary services provided to eligible clients. Prior authorization of payment for specific covered services, as a utilization control tool, is one method used to meet this responsibility. The Department uses prior authorization to –

1. Safeguard against unnecessary or inappropriate care and services;
2. Safeguard against excessive payments;
3. Assess the quality and timeliness of service;
4. Determine if less expensive, alternative care, services, or supplies could be used;

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5. Promote the most effective and appropriate use of available services and facilities; and
6. Eliminate mis-utilization practices of providers and clients.

3-005.01 Services Requiring Prior Authorization: Services which require prior authorization of payment, prior authorization requirements, and methods are listed in the chapter of the Nebraska Department of Health and Human Services Finance and Support Manual related to the specific type of service.

3-005.02 Limitations of Prior Authorization: Prior authorization is issued only if the client is or was eligible for NMAP for the period for which services are authorized. If the client becomes ineligible for NMAP (through spend-down, suspension, or closing of the case) during the authorization period, the authorization is invalid in the period of ineligibility. The authorizing agent shall not submit a prior authorization request until eligibility for NMAP has been determined. Prior authorization is not transferable to other clients or other providers.

3-005.02A Medicare/Medicaid Eligibility: If the client is eligible for Medicare as well as Medicaid and the requested services are covered by Medicare, prior authorization is not issued. In some cases, as defined in the specific service policy, the provider must receive a denial of coverage from Medicare before a prior authorization is issued. The provider shall submit a copy of the denial with the claim form to receive payment.

3-005.03 Notification of the Client: The provider or local office shall notify the client of approval or denial of prior authorization according to the prior authorization procedures under the individual chapters of this Title.

3-006 (Reserved)

3-007 (Reserved)

3-008 Co-payments

3-008.01 Co-payment Schedule: The Department has established the following schedule of co-payments for Medicaid services.

<u>Service</u>	<u>Amount of co-payment</u>
Chiropractic Office Visits	\$1 per visit
Dental Services	\$3 per specified service
Durable Medical Equipment	\$3 per specified service
Drugs (except birth control)	
Generic drugs	\$2 copay
Brand name drugs	\$3 copay
Eyeglasses	\$2 per frames, lens, or frames with lens

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Hearing Aids	\$3 per hearing aid
Inpatient Hospital	\$15 per admission
Mental Health/Substance Abuse Visits	\$2 per specified service
Occupational Therapy (non-hospital based)	\$1 per specified service
Optometric Office Visits	\$2 per visit
Outpatient Hospital Services	\$3 per visit
Physical Therapy (non-hospital based)	\$1 per specified service
Physicians (M.D.'s and D.O.'s) Office Visits	\$2 per visit (Excluding Primary Care Physicians Family Practice, General Practice, Pediatricians, Internists, and physician extenders {including physician assistants, nurse practitioners, and nurse midwives} who provide primary care services)
Podiatrists Office Visits	\$1 per visit
Speech Therapy (non-hospital based)	\$2 per specified service

Note: See 471-000-126 for a list of procedure codes for the services that are subject to co-payment requirements. Drug products exempted from the co-payment requirements are indicated on the Department's Drug Name/License Number Listing microfiche.

3-008.01A Excluded Services: The following services are excluded from the above co-payment requirement by federal regulations:

1. Emergency services provided to treat an emergency medical condition in a hospital, clinic, office or other facility that is equipped to provide the required care. An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, that a prudent lay person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman and her unborn child) afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person; and



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2. Family planning services, supplies, and drugs (such as contraceptive pills, creams, lotions etc.) provided to individuals of child-bearing age.

3-008.02 Covered Persons: All Medicaid-eligible adults age 19 or older listed below are subject to the co-payment requirement:

1. Adults eligible under the Aid to Dependent Children (ADC) program;
2. Adults eligible under the Aid to Aged, Blind, and Disabled (AABD) program;
3. Adults eligible under the Refugee Resettlement Program (RRP);
4. Individuals who are receiving extended assistance for former Department wards; and
5. Individuals age 19 and 20 eligible under the Ribicoff program.

The client's Medicaid eligibility document will indicate whether the client is subject to the co-payment requirement. The provider may also verify the client's co-payment status by contacting the Nebraska Medicaid Eligibility System (NMES) or by using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see 471-000-50 Electronic Transactions Instruction).

3-008.02A Change in Client's Co-payment Status During the Month:

The client's co-payment status may change during the month. If the client's co-payment status changes during the month (for example, admission to a medical institution or alternate care as defined in 471 NAC 3-008.02B, or verification of pregnancy), the provider may submit documentation regarding co-payments made or collected erroneously and the Department will make the appropriate adjustments to the claim. The provider shall refund the client (either cash or credit) when a co-payment is erroneously collected. Providers may contact the Nebraska Medicaid Eligibility System (NMES) or use the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to verify the client's co-payment status.

3-008.02B Exempted Persons: The following individuals are exempted from the co-payment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);
3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;

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4. Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes; and
5. Indians who receive items and/or services furnished directly by an Indian Health Care Provider or through referral from an Indian Health Care Provider under contract health services.
6. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Mental Retardation or Related Conditions; the Home and Community-Based Waiver for Children with Mental Retardation and Their Families; the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities or the Early Intervention Waiver;
7. Individuals with excess income (over the course of the excess income cycle, both before and after the obligation is met); and
8. Individuals who receive assistance under the State Disability Program (SDP).

3-008.03 Client Rights and Responsibilities: Clients listed in 471 NAC 3-008.02 as covered persons are required to pay the provider the applicable co-payment amounts as specified in 471 NAC 3-008.

If a client believes that a provider has charged the client incorrectly, the client must continue to pay the co-payments charged by that provider until the Department determines whether the co-payment amounts are correct.

The client has the right to appeal under 465 NAC 2-001.02.

3-008.04 Collection of Co-payment: The provider shall collect the co-payment from the client when the service is provided. The provider shall not refuse to provide services to the client if the client is unable to pay the co-payment amount at the time of the service. This does not alleviate the client's liability for the co-payment amount nor does it prevent the provider from attempting to collect the co-payment amount.

If it is the routine business practice of the provider to refuse service to any individual with uncollected debt, the provider may include uncollected co-payments under this practice. Providers shall give sufficient notice to the client before services can be denied.

Providers shall bill their usual and customary charge regardless of whether the co-payment has been collected. The provider shall not enter the co-payment as a "prior payment or amount paid" amount on the claim.

A provider shall not establish a policy to automatically waive co-payments or deductibles established by the Department. A provider shall not advertise or promote through newspapers, magazines, circulars, direct mail, directories,



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radio, television, or otherwise that the provider will waive the collection of all or any portion of the required co-payments or deductibles.

The provider shall not collect a co-payment amount that exceeds the provider's usual and customary charge or the NMAP payment. Co-payment collected from the client must be the lowest of the established co-payment amount, the provider's usual and customary charge, or the NMAP payment.

Also see 471 NAC 3-008.02A.

3-008.05 Third Party Liability: For Medicaid clients enrolled in commercial HMO or PPO plans, the Medicaid co-payment may apply.

3-008.06 Medicare: For Medicare/Medicaid eligible clients, the Medicaid co-payment applies. NMAP pays Medicare co-insurance and deductible amounts on Medicare-approved services minus any Medicaid co-payment.



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safely be performed according to exact directions, which do not require alterations of standard procedure, and for which the results and client's responses are predictable (e.g., recording height and weight, monitoring blood pressure, monitoring blood sugar, and providing insulin injections as long as the client is stable and predictable). The need for health maintenance activities is determined on an individual basis.

- e. **Housekeeping Activities:** Cleaning of public areas as well a client's private residence, such as dusting, vacuuming, cleaning floors, cleaning of bathroom and making and changing of the bed. Bed linens will be changed as soiled but at least weekly. Clean bath linens shall be made available daily.
- f. **Laundry services:** Washing, drying, folding and returning client's clothing to his/her room. Dry cleaning is the responsibility of the client but the facility will assist the client in arranging for this service if needed.
- g. **Meal Service:** Three meals per day, seven days per week, as well as access to between meal snacks. Each meal must consist of a variety of properly prepared foods containing at least one-third of the Minimum Daily Nutritional Requirements for adults, and take into account cultural and personal preference for foods served at specific times of day. Meals will be delivered to the client's room for those experiencing temporary illness.
- h. **Medication Assistance:** Assistance with the administration of prescriptions and non-prescription medications.
- i. **Personal Care Services:** Assistance with ADL's (e.g., transferring, dressing, eating, bathing, toileting, and bladder and bowel continence). The facility shall also provide assistance with eating. Assistance with eating includes opening packages, cutting food, adding condiments, and other activities which the client is unable to perform for his/her/herself in preparing to eat the food. If the client is unable to eat independently, the facility shall feed the client or shall assure other arrangements are made for this care. Personal care will be provided to the client in a manner in which the individual maintains as much independence and privacy as possible. The amount and degree of personal care services is determined on an individual basis.
- j. **Transportation Services:** Transporting, or making arrangements for transporting a client to and from local community resources identified during client assessment and included in the Plan of Services and Supports as directly contributing to the ability of the individual to remain in an assisted living facility.

Resident Service Agreement: The provider shall ensure that there is a written plan for each client. The written plan must be jointly developed with the client, services coordinator, and facility staff, and must include the client's strengths, needs, and desired outcomes, and the service components to

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be provided. The plan must also include an up-to-date listing of the client's current medications and treatments, any special dietary requirements, and a description of any limitations to participate in activities. Assisted living staff shall, together with the client and services coordinator, review and revise the resident service agreement as appropriate, but at least annually. A copy must be submitted to the client's services coordinator.

When a facility or the services coordinator determines that a client's needs are beyond the facility's capabilities or capacities to meet the client's needs, the services coordinator and the client will initiate alternative arrangements.

4. ASSISTED LIVING STANDARDS

HHS annually contracts with waiver providers of assisted living to ensure that all applicable federal, state, and local laws and regulations are met.

Facility Standards:

- a. Each assisted living facility shall be licensed as an assisted living facility and certified as an Assisted Living Service waiver provider, as defined in 480 NAC, Chapter 5, by the HHS System.
- b. Licensed nursing facilities in the State of Nebraska may apply to the Department for funding to convert all or a portion of their operation to assisted living under provisions of the Nebraska Health Care Trust Fund Act will not be required to meet the provisions of an independent living unit, independent bedroom, and independent toilet facilities for a period not to exceed six months from the effective date of the assisted living license.
- c. The facility shall provide a private room with bath consisting of a toilet and sink for each client receiving waiver assisted living service. Any facility that receives funding through the Nebraska Health Care Trust Fund Act shall provide a private room with bath consisting of a toilet, sink, and tub or shower for each client receiving waiver assisted living service. Semi-private rooms shall be considered on an individual basis (e.g., couples), and require prior approval of the HHS System.
- d. Assisted living service provided in facilities also providing nursing facility care shall be separately licensed and separately located in another wing or section of the building, with separate dining and common areas. Individual facility exceptions to separate dining areas may be considered based on the facility's assisted living philosophy, and requires prior approval of the HHS central office.

For general provider standards, see 480 NAC 5-006.

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5. ASSISTED LIVING RATES

The frequency of service is a month. Medicaid payment for assisted living service is through rates established by HHS Central Office. Variable rates may be utilized and may change annually.

6. ASSISTED LIVING RECORD KEEPING

The provider shall maintain the following in each client's file:

- a. The current Resident Service Agreement;
- b. The current Plan of Services and Supports; and
- c. Phone numbers of persons to contact in case of an emergency and the client's physician's name and phone number.

For general provider record keeping, see 480 NAC 5-011.

