AGED & DISABLED MEDICAID WAIVER

Chore Services

Provider Handbook

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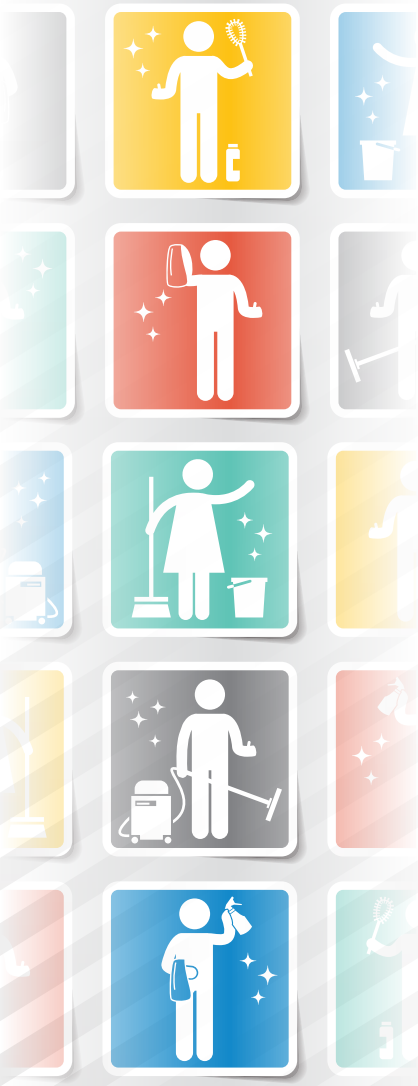
Department of Health & Human Services
DHHS
NEBRASKA



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Introduction

Welcome! Chore services for the Aged and Disabled Medicaid Waiver program (AD Waiver) - provides assistance to persons who are aged or have disabilities.

"Chore is a service for adults which includes general household activities necessary for maintaining and operating the individual's home when the individual is unable to perform these activities. Home care/chore activities provided are limited to those activities that are required to maintain the client in a healthy and safe environment." (480 NAC 5-005.E)

Department of Health and Human Services (DHHS) - approved service providers have an important role in the community. Providers of these services help persons who are aged or have disabilities to have choices in how to live and where to live.

Some persons who are aged, or have disabilities, want to live in their own home or apartment. However, they may need some help with chores. DHHS approved service providers can help these persons with those tasks.

If a person or agency is approved as a DHHS service provider they would not be an employee of the State. Rather, they are considered an "independent contractor"—an individual or agency that contracts with the client to do certain tasks. Providers are paid a reasonable rate by DHHS -- on behalf of the client.

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How to Become a Chore Service Provider for DHHS

Working for a person who is aged or has disabilities is a serious responsibility. These clients depend on their provider to help them with their daily needs and safety. To be approved by DHHS, a provider must:

1. Agree to background checks, including:
   - Criminal history
   - Adult protective services registry
   - Child central registry
   - Sex offender registry
   - License Information System
2. Meet the standards listed in the Service Provider Agreement. The Services Provider Agreement is a legally binding document describing the services to be provided, the maximum rate allowed, provider responsibilities and the responsibilities of Department staff.
3. Complete the provider enrollment process online via the Maximus portal. If the potential provider does not have access to a computer they should inform the "Resource Developer" with whom they are working.

Resource Developers monitor service providers. A Resource Developer can be found at a local DHHS office, an Area Agency on Aging, or a League of Human Dignity office.

Every DHHS-approved service must meet "general standards." These standards are listed below. A Resource Developer will review the standards with the prospective provider.

To be a DHHS-approved service provider, all providers must meet the following general provider standards:

1. Follow all Nebraska Health and Human Services policies and procedures.
   - Bill only for services which are authorized and actually provided.
   - Submit billing documents after service is provided and within 90 days.
2. Accept payment as payment in 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 she/he is the legally responsible relative:
   - Spouse of a client
   - Parent of a minor child who is a client

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4. Not discriminate against any employee, applicant for employment, or program participant because of race, age, color, religion, sex, handicap, or national origin.
5. Retain financial and statistical records for six (6) years from the 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 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 client'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 endanger individuals for whom 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, skills, and/or abilities necessary to perform the task(s).
18. Report changes to appropriate Department staff (e.g. the client's Service Coordinator). Reportable issues include informing the client and their Service Coordinator if the provider is no longer able, or willing, to provide service or informing the Service Coordinator of changes in the client's well-being.
19. Agree and assure any suspected abuse or neglect will be reported to law enforcement and/or appropriate DHHS staff.

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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.

Chore providers must meet additional requirements

In addition to the general standards for all service providers, chore service has its own requirements which are listed below. Providers must certify that:

1. I am free of any communicable diseases.
2. I am physically capable of providing services and willing to provide a physician's verification statement if requested by staff.
3. I have knowledge of basic first aid skills and available emergency medical resources.
4. I will exercise reasonable caution and care in use and storage of client's equipment, appliances, tools and supplies.
5. I will provide any tools and equipment necessary to do perform authorized tasks and duties if the client does not provide them.
6. I am able to recognize distress or signs of illness in clients.
7. I am willing to talk with family/client about emergency procedures in their home.
8. I will bill only for chore services actually provided. I understand that chore services may be provided only when a client is physically present (e.g. not hospitalized or in a nursing facility)

Chore agencies have additional standards

Agency providers must:

1. Employ chore staff based upon their qualifications, experience, and demonstrated abilities;
2. Provide training to ensure chore staff is qualified to provide the necessary level of care;
3. Agree to make training plans available to the Department; and
4. Ensure adequate availability and quality of service.

If the provider is a chore service agency, as opposed to an "individual" service provider, the agency should review the complete regulations on DHHS chore service providers. The complete regulations are available, on-line, at the DHHS public website.

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The regulations on Chore Service can be found by clicking on Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities.

- Title 480 -- Home and Community-Based Waiver Services and Optional Targeted Case Management Services

Additionally, select applicable sections of the regulations are included in this handbook.

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Chore Services and Provider Responsibilities

Each client may need help with a different set of chore tasks. The client's Services Coordinator or other representative will explain the specific tasks a provider would do for each client. The services provided may be a range of activities such as, general household tasks necessary for maintaining and running a person's home when that person is unable to perform some or all of them.

They allow persons who are aged or have disabilities to maintain the highest possible degree of independence in the least restrictive environment. The client's Services Coordinator will authorize appropriate services for each client. Based on program guidelines and the assessed needs of the client, the potential services include:

- **Bill paying** – assisting in organizing and/or paying bills
- **Essential shopping** – getting food, clothing, or personal care items
- **Food preparation** – prepare meals necessary to maintain the independence of the client with supplies provided by the client
- **Housekeeping activities** – cleaning and caring for household equipment, appliances, or furnishings, using supplies provided by the client
- **Laundry** - washing, drying, ironing, folding, and storing laundry in the client's home; or using laundromat services for the client. The client will provide the soap and money for the laundromat
- **Personal care** – Assistance with activities of daily living including bathing, shaving, grooming, eating, mobility, toileting, and transfers.
- **Simple home repairs and maintenance** – Making minor repairs to the house, furnishings or household equipment, removing snow or ice, and cleaning water drains.
- **Supervision** – Monitoring the client as identified in the assessment and performing other authorized activities necessary to provide for the safety of the client.
- **Specialized Procedures** – Performing tasks such as insertion and care of catheters, irrigation of any body cavity, application of dressings involving prescription medication and sterile techniques, giving injections into veins, muscles or skin, drawing up insulin syringes, administration of oxygen, or other health maintenance activities covered by the Nebraska Nurse Practice Act (Neb Rev. Stat. §71- 1, 132.30) ONLY when under the direction of a competent adult client or the direction of a caregiver of an incompetent adult.

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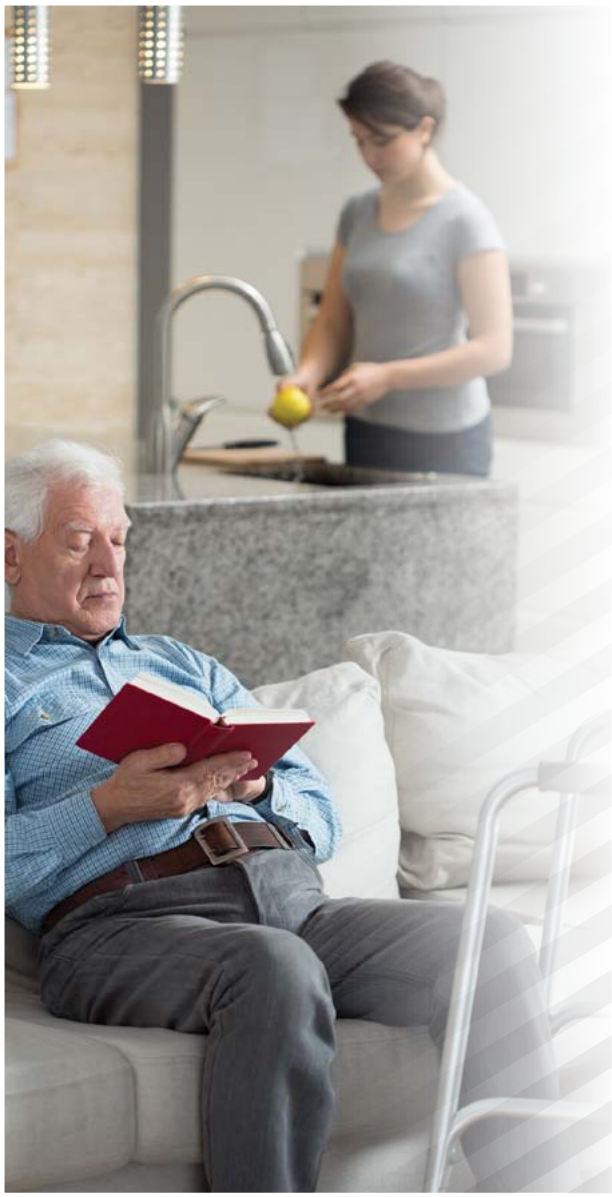
The 'Service Authorization'

For DHHS to pay an approved provider for a service, a Service Coordinator must first "authorize" the provider to do the service. A current, written service authorization for each client is required in order to be paid to provide services. It will state what type and how much service a provider is authorized to provide. Services should not be provided until a written service authorization is in-hand! Be sure the services provided are within the authorization dates.

Can an individual provider 'subcontract' a service authorization?'

No. Only the person who passed the background checks and signed the Service Provider Agreement can provide the service under that agreement. A provider cannot pay someone else to provide the contracted service in their place.



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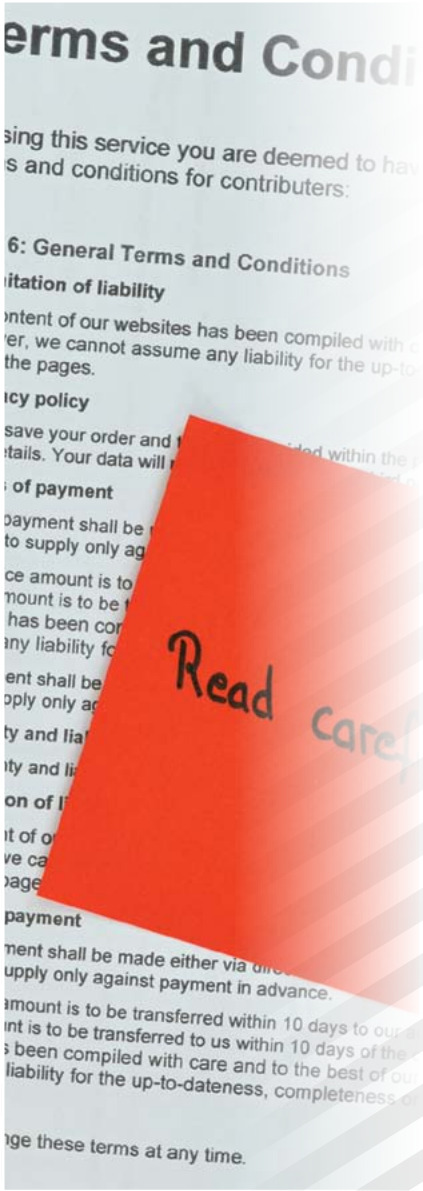

Billing DHHS for Services

What rate are DHHS-approved Chore providers paid?

If approved as a provider, rates may be established by DHHS Central Office Staff based on available funding or rates may be negotiated with the Resource Developer. Rates may be authorized by the hour, partial day, day or occurrence. Not all rate types are available to all providers. DHHS Central Office has the authority to set maximum Chore rates.

How are providers paid?

A Resource Developer will explain how to bill for services.

Basically:

1. Record services provided – dates, in and out times, and tasks performed -- on a form provided by the Resource Developer. Submit a separate time sheet for each client.
2. The client must also sign that services billed were performed.
3. The billing document is submitted along with the time sheet. The Resource Developer will provide information on where to submit it.
4. Designated staff will check the billing to assure there are no errors, and process it for payment.
5. When the billing is approved, it is then forwarded to the claims center for final processing. Payment is made after final processing is completed. Payment is made through the method chosen during provider enrollment.
6. A payment takes about 15 days from when the local office receives it.

Billing should be submitted only after the service is provided and within 90 days.

As part of agreeing to become a chore provider, providers understand they cannot submit billing for days they or the client spend in a hospital, nursing facility, rehabilitation, or correctional facility. Additionally, providers understand they are not to bill for time they did not work with/for the client. Any such attempt to bill for payment may be considered fraud and is subject to prosecution and/or civil monetary damages.

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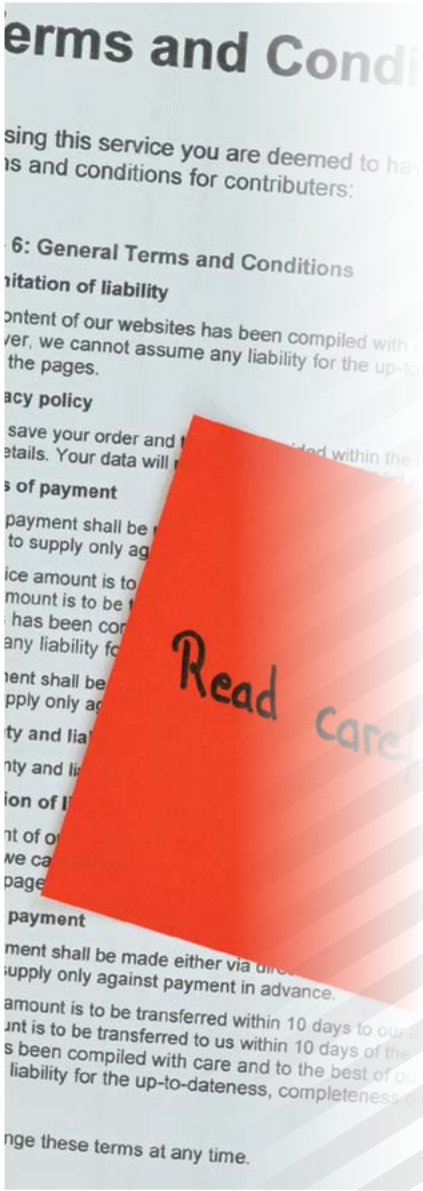

Does DHHS withhold Social Security tax?

Social security taxes are withheld based upon provider type. DHHS withholds Social Security taxes (Federal Insurance Contribution Act, FICA) from provider payments in some situations. The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not associated with an agency.

DHHS acts on behalf of the client as an agent to withhold the mandatory taxes from some provider's earnings and pays the client's matching share to the Internal Revenue Service (IRS). DHHS withholds the tax from affected providers. If the provider's earnings do not reach the mandatory annual amount, the amount that has been withheld is refunded to the provider.

What records must a provider keep?

Yes. As a DHHS-approved service provider copies of the following materials must be retained for six years:

1. Copies of time sheets and billings that support what services were provided, for each client served.
2. Service Provider Agreement with DHHS.
3. All correspondence from DHHS regarding this service or specific clients.

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Service provider rights and responsibilities

DHHS-approved service providers have certain rights and responsibilities. Providers of AD Waiver services are Medicaid providers and have the following rights and responsibilities:

1. The responsibility to maintain compliance with all applicable provider standards and to report any changes that may effect this compliance;
2. The right to have provider standards correctly and consistently applied;
3. The responsibility to provide correct and current information about the Social Security number or federal identification number;
4. The right and responsibility to inform Services Coordination when there is a change in the client's situation which may require a change in the client's Plan;
5. The responsibility to provide quality services;
6. The responsibility to treat the client with respect, to be dependable, and to schedule service delivery with the client and to notify the client of any changes;
7. The right to receive information needed to do the job;
8. The responsibility to keep client-specific information confidential;
9. The responsibility to provide services according to the authorization provided by the client's Services Coordinator and to bill only for services authorized and provided.
10. The right to receive notice when service authorization will end before the originally-stated end date.
11. The right to complain or to file an appeal if the provider agreement is denied or terminated.

What if changes need to occur to the service provider agreement?

A provider and Resource Developer must sign and date a modification to the agreement or a written amendment to change the existing service agreement to:

1. Add a service; or
2. Change a rate.

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What if changes to provider information occur after signing up to provide services?

Providers must report changes in their personal information via the Maximus portal. Changes, such as an address change which does not affect the service location, change in provider name, FID number, or Social Security number should be updated as soon as the change and any required supporting documentation e.g. court order showing name change, has been received.

Where can regulations governing Home Care/Chore be found?

If you want to learn more about being a DHHS service provider, you can read the complete regulations on-line. You can find the regulations on Chore Service clicking on Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities.

- Title 480 -- Home and Community-Based Waiver Services and Optional Targeted Case Management Services

Additionally, select applicable sections are included in this provider handbook.

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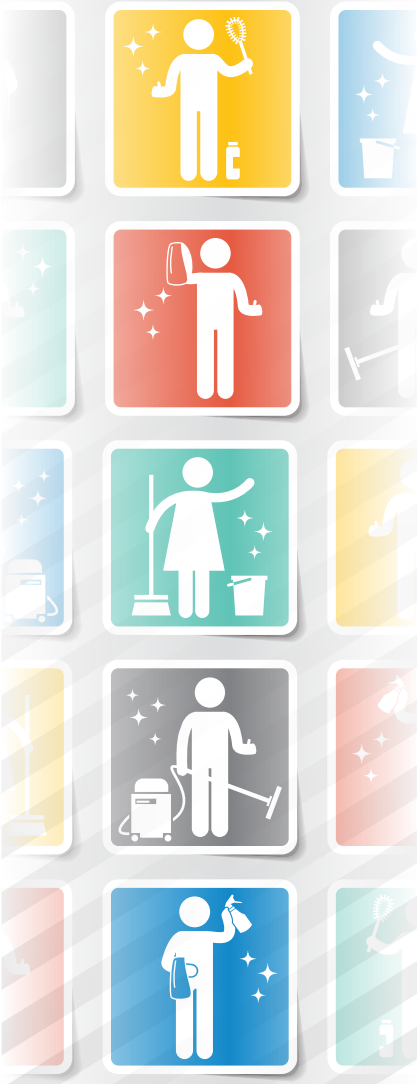

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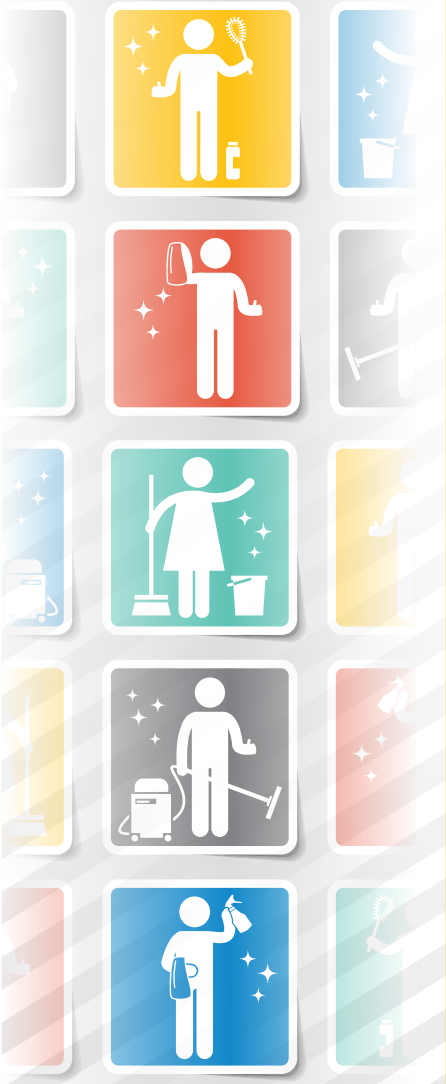

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 98933
LINCOLN NE 68509-8933

Case Name – CLIENT'S NAME
CONTACT – SC NAME
Phone Number - (402)111-0000
Toll Free Number - (877)213-4754
Fax Number - (402)111-1111
Date of Notice - 06-20-2014
Mail Date - 06-21-2014

PROVIDER, INC
0000 HUSKER DR
LINCOLN NE 68500

PROVIDER AUTHORIZATION UPDATE
Waiver Aged and Disabled
UPDATED ON 06-20-2014 AT 10:06am

PROVIDER INC
Provider Telephone - (402)000-0000 Provider ID: 22222222

On behalf of the client named below, the Department of Health and Human Services authorizes you to provide the service indicated below. This document authorizes you to provide and bill for the listed service in accordance with the units of service, the rate of charge and the authorization period stated. In providing authorized services you accept responsibility and liability for injury to client(s) or damage to clients' property resulting from negligence by you or your employees in the provision of services. All billings must be received by the Department within ninety (90) days of service provision.

CLIENT'S NAME
1234 ANY STREET
LINCOLN NE 00000

Case Number: 12345678
Telephone: (402)222-2222

Authorized Service: CHORE
Service Code: 00001691

Authorized Clients	Client ID#	Authorization #
CLIENT'S NAME	**12345678**	00000000

Authorized Period: 07-01-2014 through 06-30-2015

Authorized Units:
2160.00 Hours

Authorized Rate:
10.000 per hour effective 07-01-2014

CHORE TASKS TO INCLUDE PERSONAL CARES, HOUSEKEEPING, LAUNDRY, ESSENTIAL SHOPPING AND MEAL PREP. SERVICES AUTHORIZED UP TO 30 HOURS PER WEEK OR 124 HOURS PER MONTH. HOURS ARE TO BE SHARED AMONGST ALL PROVIDERS. PLEASE BILL MONTHLY.

EXAMPLE

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ATTACHMENT B

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N-FOCUS BILLING DOCUMENT

All billings must be received within ninety (90) days of service provision

Claim Number: 34567891

Date: 07/01/15 to 06/30/15	DHHS Provider ID: 22222222
Office No: 444 Office Name: LINCOLN	Phone Number: 402-000-1111
Provider Name: PROVIDER, INC 0000 HUSKER DR LINCOLN, NE 68500	By signing this form, the claimant certifies that the information contained in this claim is accurate and all services provided were in compliance with Department of Health and Human Services Nebraska Administrative Codes Titles 465, 471, 473, 474, and 480, whichever are applicable. The claimant is aware that a false claim may result in prosecution for fraud. Under penalty of applicable Federal and State Laws, I certify that representation herein are true and complete, and that no additional payment will be claimed.

Ln	Client Name	Client ID Number	Authoriz. Number	Service Code	Service From Date	Service Thru Date	Freq	Units	Rate	Total Charge	Cust Oblig	DHHS Charge
1	NAME, CLIENT'S	12345678	00000000	1691			HR					
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Provider/Preparer Signature	Signature Date	Service Approval Signature	Approval Date	Total DHHS Charge

For information about the status of your claim, call ACCESSNebraska at 1-800-383-4278. For information regarding where to submit your claim see the reverse of this form.

DHHS-5N Rev. 10/11

Department of Health & Human Services
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SECTION 6

ATTACHMENT C

Division of Medicaid and Long-Term Care / División de Medicaid y Cuidado de Largo Plazo
Provider Record of Services / Registro del Proveedor de Servicios

This Record of Services is a legal document completed by you to record the dates and units of service provided. Both the provider and the client must sign and date this record verifying the accuracy of this information. A description of services provided must be recorded. This Record of Services with the billing document must be submitted within 90 days of service and can be submitted semi-monthly or monthly. Return this Record of Services with the billing document to your specified worker. The Provider is responsible for keeping records for six years.
Este registro de servicios es un documento legal efectuado por usted para registrar las fechas y unidades de servicio prestados. Tanto el proveedor como el cliente deben firmar y fechar este registro verificando la exactitud de esta información. Una descripción de los servicios prestados debe ser registrada. El Registro de Servicios con el documento de facturación deben ser enviados dentro del plazo de 90 días del servicio, y pueden ser enviados quincenalmente o mensualmente. Regrese este Registro de Servicios con el documento de facturación a su trabajador asignado. El Proveedor es responsable de mantener los registros por seis años.

Client's Name / Nombre del Cliente	Client's ID Number / # de Identificación del Cliente	Provider Name / Nombre del Proveedor

Service Provided: Servicio Prestado:		
Child Care/Cuidado Infantil (9704) In-Home Child Care/Cuidado Infantil en el Hogar (2500) Chore/Quehaceres (1691)	Home Again (8234) Independence Skills Building//Desarollo de Destrezas para la Independencia (8382) In-Home Independence Skills Building/ / Desarollo de Destrezas para la Independencia en el Hogar (9233)	Respite/Relevo para el descanso del cuidador (7395) In-Home Respite/Relevo para el descanso del cuidador en el hogar(1113) Personal Assistance Services (4475) Servicio de Asistencia Personal (4475)

Month/Mes | Year/Año

Date/ Fecha	Service Code/ Código del Servicio	Time in and out/ Tiempo de incio y de Fin			Description of Authorized Services Provided/ Descripción de los Servicios Prestados	Quarterly Units Unidades trimestrales	Hourly Units Unidades de Hora	Partial Day Units/ Unidades de Día Parciales	Daily Units/ Unidades diarias	Occurrence units / Unidades de frecuencia
		In/Incio								
		Out/Fin								
		In/Incio								
		Out/Fin								
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		In/Incio								
		Out/Fin								

I hereby certify that the above hours/days are correct and accurate and understand that fraudulent claims may result in prosecution. PPor medio de la presente doy fe de que las horas/ días arriba anotados son correctos y exactos, y entiendo que las reclamaciones fraudulentas pueden resultar en una acción penal.

Signature of Individual Providing Services/Firma del Proveedor | Date/Fecha | Provider Number/Número del Proveedo | Client/Guardian Signature/Firma del Cliente/Guardián | Date/Fecha

DISTRIBUTION: WHITE; attach to billing document/Copia Blanca; adjunte a la factura YELLOW; Provider/Copia Amarilla; Proveedor PINK; Client/ Copia Rosada; Cliente TSU 4/15 MC-37-ES (52037) 4/15

SECTION 6 ATTACHMENT D

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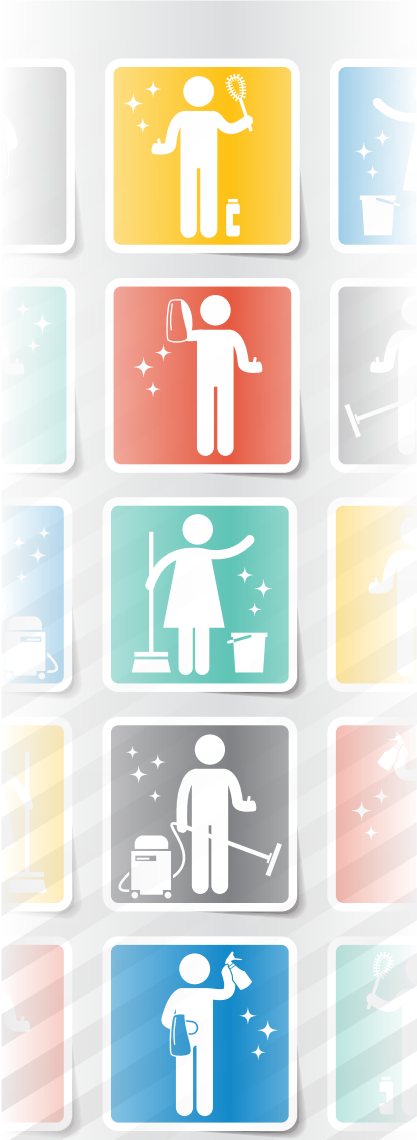

Department of Health & Human Services
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Division of Medicaid and Long-Term Care
Nebraska Service Provider Agreement
Provider Addendum

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

Provider Identification

Provider Name | Date of Birth

Social Security Number | FTIN

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. Assure 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

MS-8 (991233) 12/2015

SECTION 6 ATTACHMENT E

Department of Health & Human Services
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TITLE 480
HOME AND COMMUNITY-BASED WAIVER SERVICES
FOR AGED PERSONS OR ADULTS OR CHILDREN WITH DISABILITIES

Chapter 5 Home and Community-Based Waiver Services for Aged Persons or Adults or Children With Disabilities

5-001 INTRODUCTION

A. GENERAL INTRODUCTION

Home and community-based waiver services offer eligible persons a choice between entering a Nursing Facility (NF) or receiving supportive services in their homes. Medicaid funding through the Nebraska Medical Assistance Program (NMAP) is used to fund either service option. The average cost of waiver services funded by Medicaid must not exceed the average cost to Medicaid for NF services.

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

1. Have care needs equal to those of Medicaid-funded residents in Nursing Facilities;
2. Be eligible for Medicaid; and
3. Work with the services coordinator to develop an outcome-based, cost effective service plan.

B. PHILOSOPHICAL BASE

Waiver services build on client/family strengths and are intended to strengthen and support informal and formal services already in place to meet the needs of the client and are not intended to replace them.

Waiver services utilize a self-directed services philosophy and vision that holds that each client has the right and responsibility to participate to the greatest extent possible in the development and implementation of his/her service plan.

The services coordinator and the client together shall identify appropriate levels of services coordination by considering risk factors or capacity to direct their own services. The services coordination levels include:

- Self-Directed Services Coordination
- Supportive Services Coordination
- Comprehensive Services Coordination

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Elements in the following areas shall be considered to determine the level of services coordination both initially and as service levels change:

1. Determination of strengths, priorities, and resources.
2. Planning for services.
3. Connecting with needed services.
4. Advocacy.
5. Monitoring.

5. CONNECTING/LINKING NEEDED SERVICES

PURPOSE: To translate the plan of services and supports into action.

To locate or develop resources to address identified service gaps.

To identify and promote an effective/optimum use of community resources.

The services coordinator shall prior authorize waiver services for up to a 12-month period, based on the plan of services and supports and the results of ongoing monitoring activities. Waiver services may not be authorized until the client's Medicaid eligibility has been determined and the waiver consent form has been signed.

The services coordinator shall provide a written description to the provider, clearly defining the parameters of service delivery. This must include at least the amount and frequency of service provision, specific service components authorized, and any applicable time limitations. Any applicable conditions or limitations relate solely to the eligibility of the waiver client and program policies and do not constitute an effort to directly control contract performance by the provider.

C. NOTIFYING OF ADVERSE DECISIONS

3. Provider Notice

When a waiver client's services are being changed or terminated, the services coordinator shall provide written notice to the provider of the change in service provision or termination of payment for waiver services.

No provider notice is issued when service ends at the end of the service authorization period.

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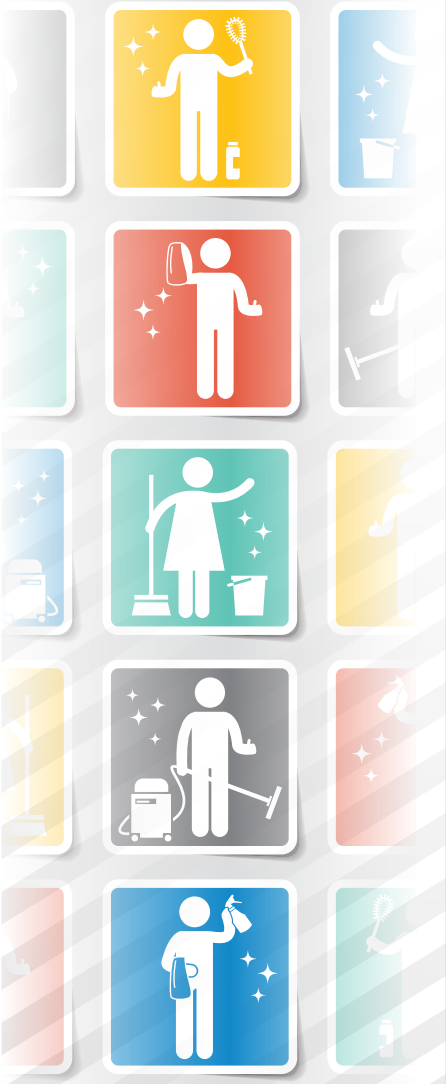

5-005 WAIVER SERVICES

Medicaid services available to persons eligible for this home and community-based waiver program are:

A. Adult Day Health Care;
B. Assisted Living Service;
C. Assistive Technology and Supports;
D. Child Care for Children with Disabilities;
E. Home Care/Chore;
F. Home-Delivered Meals;
G. Home Modifications;
H. Independence Skills Management;
I. Nutrition Services;
J. Personal Emergency Response System;
K. Respite Care; and
L. Transportation.

E. HOME CARE/CHORE

1. Home care/chore description

Home care/chore is a service for adults which includes general household activities necessary for maintaining and operating the individual's home when the individual is unable to perform these activities. Home care/chore activities provided are limited to those activities that are required to maintain the client in a healthy and safe environment.

Any or all home care/chore activities may be provided to the client as documented in the plan of services and supports. These include bill paying; errand service; essential shopping; food preparation; housekeeping activities; laundry service; personal care service; simple home repairs and maintenance; and supervision.

The need for home care/chore services must be reflected in one or more assessment areas of the client's plan of services and supports.

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2. Home care/chore activities and conditions

The following home care/chore activities are those which could normally be performed by the client, but which the client is presently unable to perform. The need for each activity must be identified during client assessment.

Full-Time/Live-In housekeeping: The services coordinator shall authorize full-time housekeeping only when the client is living alone or living with only minor children, or when the circumstances of eligible individuals residing together indicate this need. The housekeeper may live in. A full-time housekeeper shall -

a. Provide the following activities of home/care chore, as appropriate:

(1) Bill Paying: Assisting clients to organize and/or pay bills.
(2) Errand Service: Providing service in relation to needs described for escort service when not generally accompanied by the client. If the client does accompany the provider, the provider shall not bill an additional amount for transportation.
(3) Essential Shopping: Obtaining food, clothing, housing, or personal care items.
(4) Food Preparation: Preparing meals necessary to maintain independence. The client shall provide necessary meal preparation supplies.
(5) Housekeeping Activities: In-home cleaning and care of household equipment, appliances, or furnishings. The client shall provide necessary supplies.
(6) Laundry Service: Washing, drying, ironing, folding, and storing laundry in the client's home; or utilizing laundromat services on behalf of the client. The client shall provide soap and machine-use fees.
(7) Personal Care Service: Limited to a non-legally responsible relative providing basic personal care and grooming including bathing, shaving, shampooing, assisting with dressing, ambulation, and toileting. This service is identical to what may be provided through Medicaid Personal Care Aide except that non-legally responsible relatives are allowed as waiver providers even though they are excluded as regular Medicaid Personal Care Aides (see 471 NAC 15-004.02). Natural, adoptive, and stepparents of a minor age client and the spouse of a client are prohibited as providers through both the regular Medicaid Personal Care Services and the Aged and Disabled Medicaid Waiver Personal Care Service.
(8) Supervision: Staying with the client for part of a day when the client would otherwise be alone, and performing non-medical activities necessary to provide for the safety and comfort of the client.

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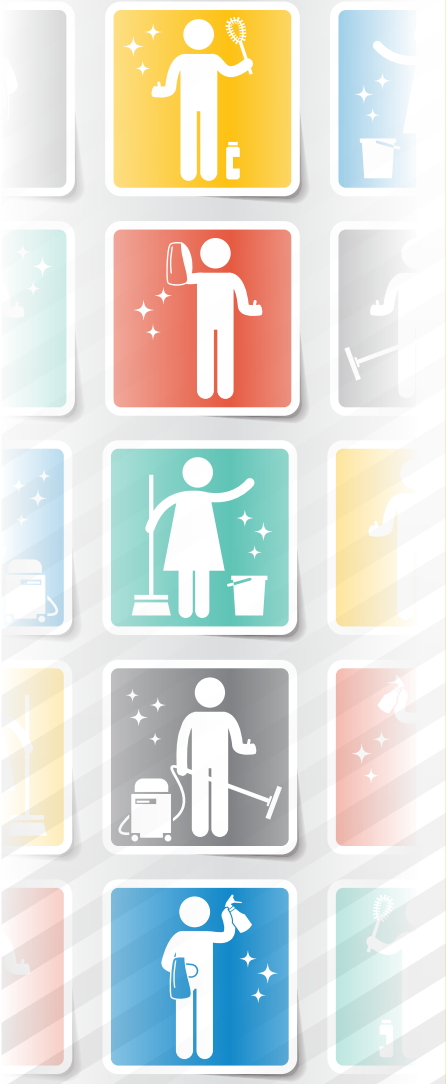

b. Provide service to only one household;
c. Be available on a 24-hour basis to provide the authorized chore components; and
d. Bill only for the days service is actually provided.

Note: If transportation service is provided by the housekeeper, s/he may be approved and bill for additional mileage as a transportation provider. Additional payment for time is not allowed.

Simple Home Repairs and Maintenance: Providing minor repair of windows, screens, steps/ramps, furnishings, and household equipment. Mowing, raking, removing trash (to garbage pickup point), removing snow and ice, and cleaning water drains may also be provided. Mowing is limited to that necessary to meet the health and safety of the client and to meet local codes.

If the client lives in a rental property, the services coordinator shall investigate the lease agreement and determine the responsibilities of the landlord to provide repairs or maintenance.

3. Home care/chore standards

A home care/chore provider may be an individual or agency. HHS annually contracts with providers of home care/chore to ensure that all applicable federal, state, and local laws and regulations are met.

The provider shall have had training and/or experience in carrying out home care/chore services comparable to those which will be authorized.

The home care/chore provider shall obtain adequate information on the medical and personal needs of each client, if applicable, and observe and report all changes to the services coordinator.

Each home care/chore provider must be at least 19 years old and shall –

a. Have knowledge of basic first aid skills and of available emergency medical resources, if providing supervision or full-time, live-in housekeeping, personal care, and escort services; and
b. Exercise reasonable caution and care in the use and storage of clients' equipment, appliances, tools, and supplies.

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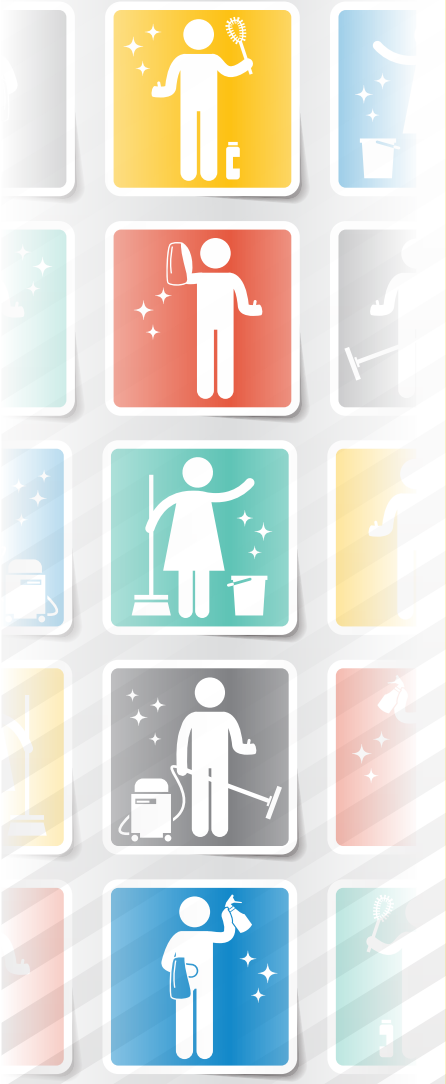

Each agency provider shall –

a. Employ home care/chore staff based upon their qualifications, experience, and demonstrated abilities;
b. Provide training to ensure that home care/chore staff are qualified to provide the necessary level of care. Agree to make training plans available to the Department; and
c. Ensure adequate availability and quality of service.

4. Home care/chore rates

Home care/chore rates shall be established by HHS central office. These established rates may change annually.

Services may be authorized in frequencies of hourly, daily, or by the job.

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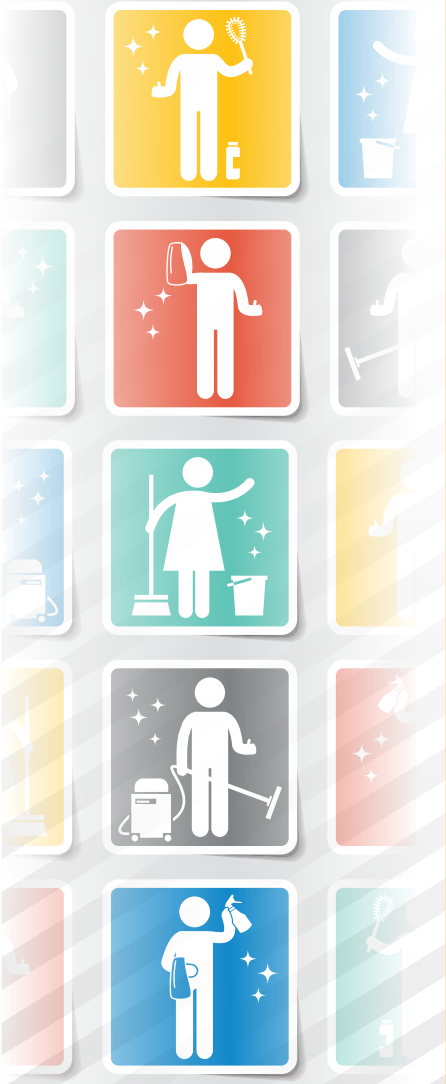

5-006 GENERAL PROVIDER STANDARDS

GENERAL STANDARDS FOR ALL WAIVER PROVIDERS: All home and community-based services (HCBS) waiver providers are Medicaid providers (see 471 NAC 2-000). All HCBS waiver providers shall meet the following general provider standards:

1. Follow all applicable Nebraska Health and Human Services policies and procedures (Nebraska Administrative Code Titles 465, 471, 473, 474, and 480).
   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 in 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 s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
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, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60.
5. Retain financial and statistical records for four 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, in accordance with 45 CFR 74.20 - 74.24; and 42 CFR 431.107. 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 s/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 (42 CFR 455.18).
10. Respect every client'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 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.
16. Allow Central Registry checks on himself/herself, family member 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, changes in client function).
19. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate HHS 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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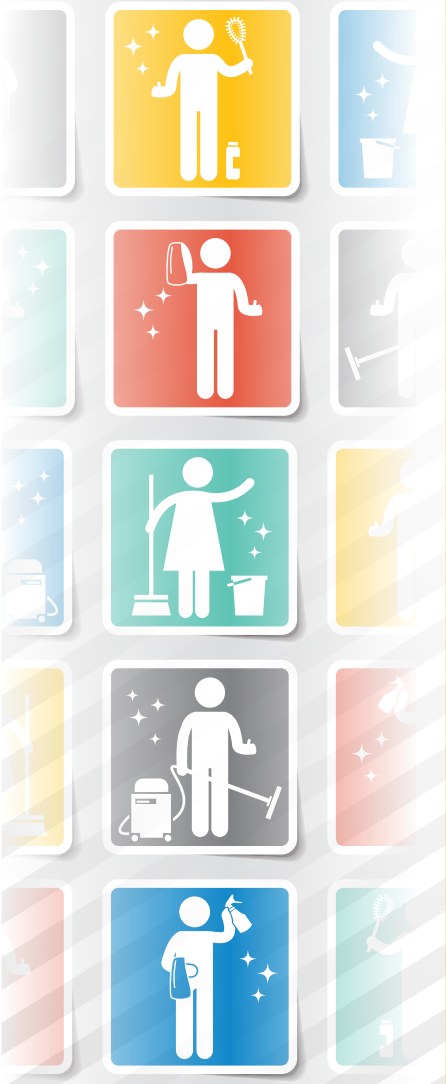

Reports of Abuse or Neglect: If the provider is an agency, HHS staff shall review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse or neglect are in place.

If the provider is an individual, HHS staff shall check the Central Registries to determine if any substantiated reports of abuse or neglect by the provider exist. If the provider provides services in his/her own home, HHS staff shall also check the Central Registries to determine if any substantiated reports of abuse or neglect by household members exist. If a report of abuse or neglect has been substantiated, HHS staff shall not contract with the individual provider.

If a report of abuse or neglect concerning a current waiver provider (or household member) as perpetrator is substantiated, staff shall immediately terminate the provider contract and notify the services coordinator.

Reports of Convictions, Unacceptable Behaviors: Before approval, the provider shall provide a statement to HHS staff, giving information concerning any felony and/or misdemeanor arrests and convictions and pending criminal charges. Any other adult regularly present in the home must also provide such a statement if services will be provided in the provider's home. These statements must be signed and dated.

If additional information is needed to determine whether the provider meets this standard (e.g., the statement shows a questionable history or the staff has reason to question the validity of the statement), HHS staff shall obtain a release of information and request information available from law enforcement. Releases must also be obtained from household members, as applicable. Refusal to sign a release of information is grounds for immediate denial or termination of provider approval.

No provider approval will be issued or remain in effect if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider or any other household members. The provider and household members shall not engage in or have a history of behavior injurious to or which may endanger the health or morals of the client.

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5-007 PROVIDER APPROVAL PROCESS

Designated HHS staff use the following policies and procedures when evaluating and approving providers of waiver services.

A. DEFINITIONS

Agency Provider: Providers who have one or more employees or will be subcontracting any one or part of the service(s) for which they are requesting approval.

Individual Provider: Providers who have no employees and will not normally be subcontracting any service(s) for which they are requesting approval. Individual providers are independent contractors and not employees of HHS or the State of Nebraska. (For the purpose of FICA withholding, the provider is considered an employee of the client.)

Provider Identification Number: A nine-digit federal identification (FID) number or a nine-digit Social Security number (SSN).

Service Provider Agreement: A legally binding document which may include an addendum and all applicable provider checklists, describing the service(s) to be provided, and the maximum rate(s) allowed for each provider. The responsibilities of the provider and of HHS are stated in the agreement.

Subcontracting: Occurs when a service provider pays someone other than an employee to provide the contracted service.

B. EVALUATING A POTENTIAL PROVIDER

HHS staff shall conduct an in-person interview with each potential provider.

If the provider does not meet standards at the time of the initial visit or interview, but is willing to correct the deficiency within a reasonable period of time, staff shall continue the evaluation process when proof of compliance is received.

All waiver providers must have a Social Security number or FID number, whichever is appropriate, and provide it to HHS before contracting.

Conflict of Interest: No employee of HHS or its subdivisions may be approved as a service provider if s/he is in a position to influence his/her own approval or utilization.

HHS Staff Relatives as Providers: HHS staff shall not approve, reapprove, evaluate, or negotiate provider agreements with, or authorize service provision from, providers to whom they are related. In situations where a HHS staff person's relative is the only resource, staff shall obtain approval from the Service Area Administrator or designee.

Client Relatives as Providers: Legally responsible relatives (i.e., spouses of clients or parents of minor children who are clients) shall not be approved as service providers for their relatives.

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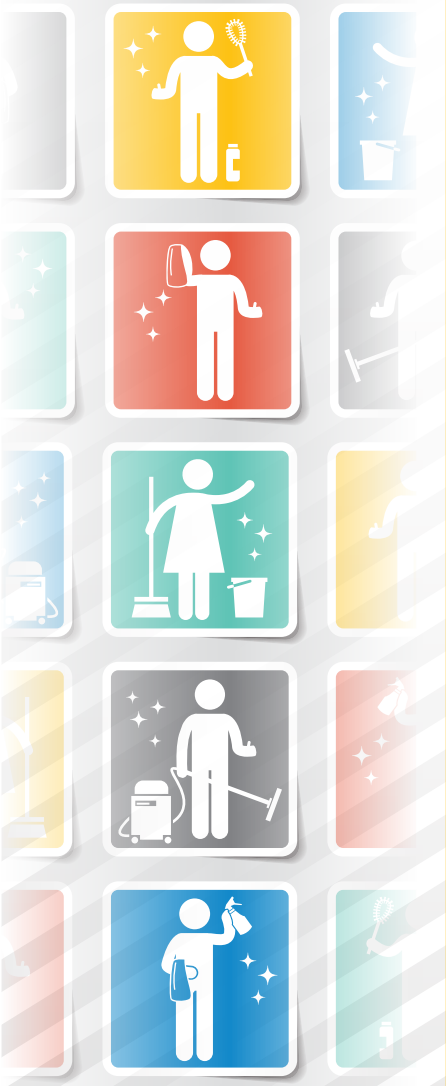

C. DENYING A POTENTIAL PROVIDER

Denial of Application: If HHS staff determine that the potential provider does not comply with all the provider standards for the service(s) to be provided, s/he shall -

1. Document the regulation(s) on which the denial is based and the reason(s) why the potential provider does not comply with the cited regulations; and
2. Send a letter of notice to the potential provider including -
   a. Explanation of the reasons for HHS's determination that the potential provider does not comply with the cited regulations, or that HHS and the potential provider have failed to agree on contracting issues;
   b. Citation of the regulations on which the denial was based; and
   c. Notification of the potential provider's right to appeal HHS's decision/action.

Voluntary Withdrawal: Written notice to the potential provider is not required if s/he voluntarily withdraws from the evaluation process.

D. COMPLETING A PROVIDER AGREEMENT

When a potential provider has met all necessary requirements, HHS staff shall complete a Services Provider Agreement. Staff shall explain that monitoring visits will occur.

If the provider is a non-emancipated minor, the signature of his/her parent or legal guardian must be obtained on the provider agreement.

Agreement Policies: The following policies govern service provider agreements:

1. Each provider must have a service provider agreement in effect before service can be authorized for purchased;
2. Resource development staff shall evaluate and approve or disapprove all service providers located within the office's jurisdiction;
3. Service provider agreements are effective up to 12 months, are never back-dated, and must be agreed upon and signed by all parties on or before the effective date; and
4. Changes in service provider agreements require agreement and new signatures of the contract. Address changes which do not affect the service location must be reported to HHS staff and do not require a new agreement.

Monitoring: Staff assigned services coordination or resource development responsibilities shall provide ongoing monitoring of the quality of services provision. Staff monitoring must also be done any time there is reason to believe a provider is not fulfilling his/her responsibilities. Staff shall report any suspected abuse or neglect to law enforcement and/or the appropriate HHS staff.

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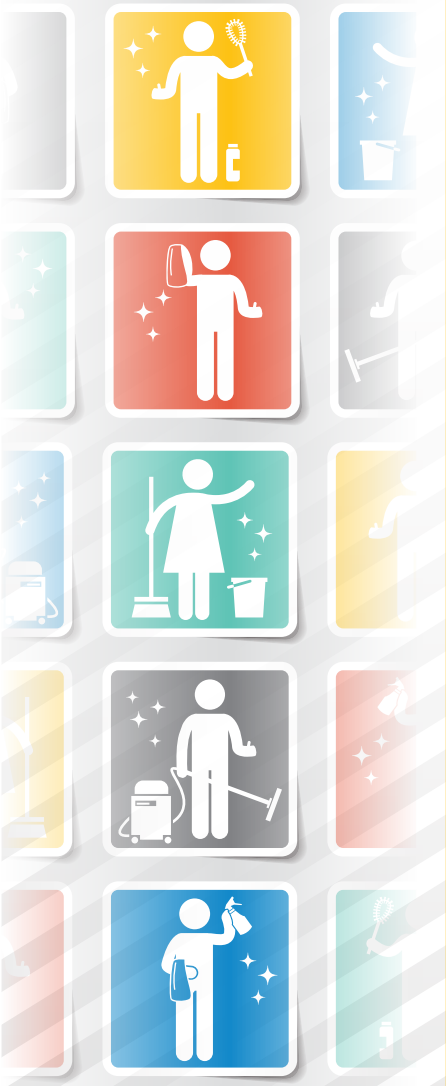

E. NOTIFYING OF PROVIDER TERMINATION

Either HHS or the provider may terminate an agreement by giving at least 30 days advance written notice. The 30-day requirement may be waived in case of emergencies such as illness, death, injury, or fire. If the provider violates or breaches any of the provisions of the Service Provider Agreement, then the agreement may be terminated immediately at the election of HHS.

When an agreement is to be terminated by HHS, staff shall -

1. Document the reason(s) for the termination and provide written notice.
2. Provide written notice which includes:
   a. Explanation of the reasons for the termination;
   b. Citation of the regulations on which the termination was based; and
   c. Notification of the provider's right to appeal HHS's decision/action.

Resource development staff shall notify services coordination staff of the provider termination.

F. APPEALING DECISION/ACTIONS

A provider of waiver services has the right to appeal any decision/action that has a direct adverse effect on the provider (see 471 NAC 2-003). Hearings are scheduled and conducted according to the procedure in 465 NAC 2-001.02 and 6-000.

5-008 PROVIDER AGREEMENT RENEWAL

HHS staff shall use established standards to re-evaluate each service provider before the expiration of a provider agreement. Provider agreements must be renewed based on the same procedures used for initial approval, including conducting an in-person interview and completing provider checklists.

5-009 RESOURCE DEVELOPMENT DOCUMENTATION

Resource development documentation shall be maintained for each provider, and retained for four years. Documentation must include:

1. Provider agreements, addendums, and checklists;
2. Verification of Central Registry checks;
3. Felony and/or misdemeanor statements;
4. Written notices to, and other communication with, the provider;
5. Activities related to services delivery monitoring;
6. Narrative documentation (e.g., resource development staff decisions and actions; and other factual, relevant information); and
7. Billing and payment records.

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5-010 PROVIDER SOCIAL SECURITY TAX WITHHOLDING

Affected Providers: In some situations, HHS withholds Social Security taxes (Federal Insurance Contribution Act, FICA) from provider payments. The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. HHS, upon receiving a signed "Employer Appointment of Agent," acts on behalf of clients who receive in-home services to withhold mandatory FICA taxes from individual providers and pays the client's matching tax share to the Internal Revenue Service (IRS).

Earnings Taxed for Social Security: Affected providers are subject to Social Security tax payment for each calendar year in which they are paid a federally determined amount or more for services provided to one client. (For example, for calendar year 1995 the base amount was $1,000 paid for FICA-covered services per client.) HHS shall withhold this tax from all payments to affected providers. If a provider's earnings do not reach this annual amount for FICA services per client, the amount withheld for that year is refunded.

Social Security Tax Rates: HHS remits to the IRS an amount equal to the current Social Security tax rate for specified "in-home" services. Half of this amount is withheld from the provider as the employee's share; the other half is provided by HHS on behalf of the client employer.

5-011 PROVIDER RECORD KEEPING

Providers of waiver services must retain for four years the following material:

1. Documentation which supports provision of services to each client served under the waiver;
2. Any other documentation determined necessary by HHS to support selection and provision of services under a plan of services and supports;
3. Financial information necessary to allow for an independent audit under the waiver;
4. Documentation which supports requests for payment under the waiver; and
5. Provider agreements with HHS.

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TITLE 471
NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

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;
13. Prescribed drugs;
14. Services in intermediate care facilities for the mentally retarded (ICF/MR);
15. Inpatient psychiatric services for individuals under age 21;

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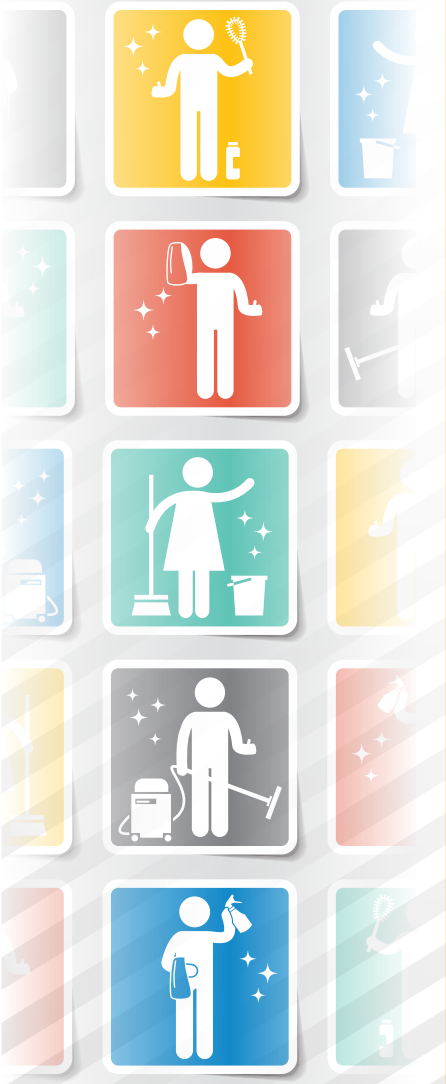

16. Inpatient psychiatric services for individuals age 65 and older in an institution for mental diseases;
17. Personal assistance services;
18. Clinic services;
19. Psychologist services;
20. Dental services and dentures;
21. Physical therapy services;
22. Speech pathology and audiology services;
23. 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.)

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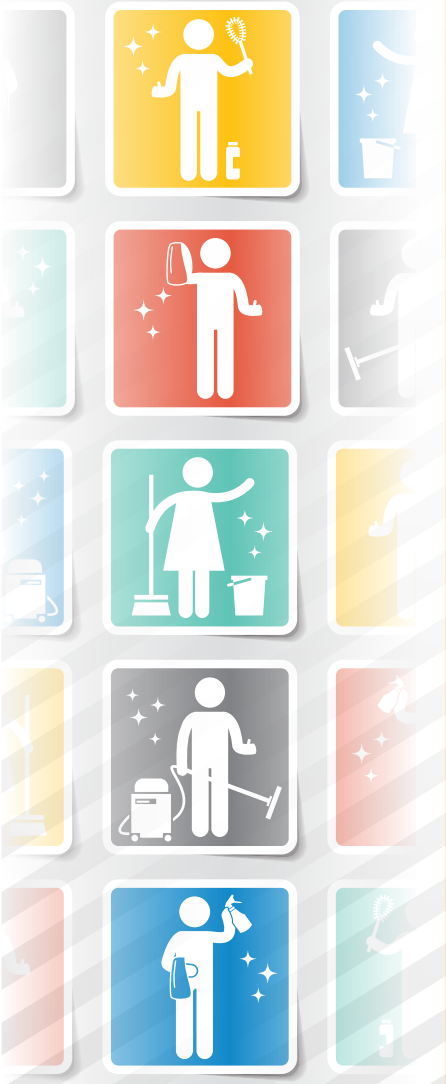

1-002.02 Limitations and Requirements for Certain Services

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.

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.

1-004 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.

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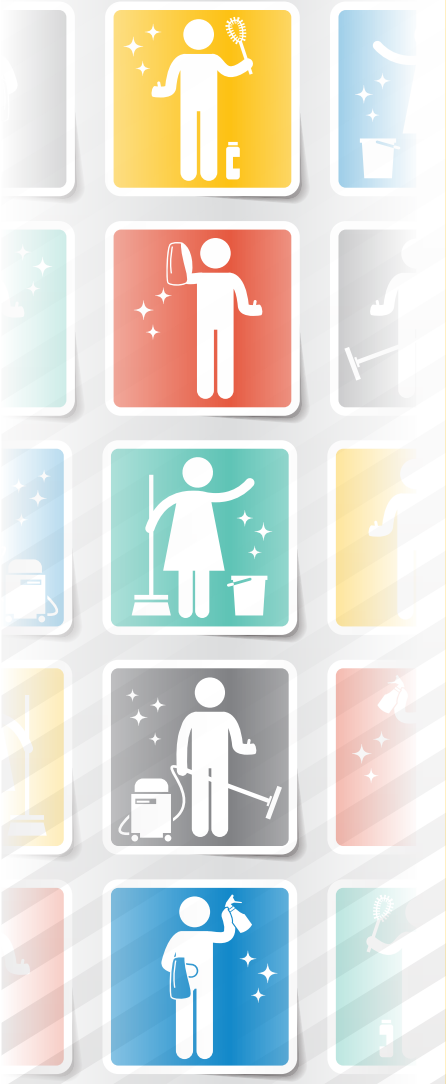

1-004.02 Free Choice of Providers: An NMAP client may obtain covered services from any provider qualified to perform the services who has been approved to participate in NMAP. The client's freedom of choice does not prevent the Department from -

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.

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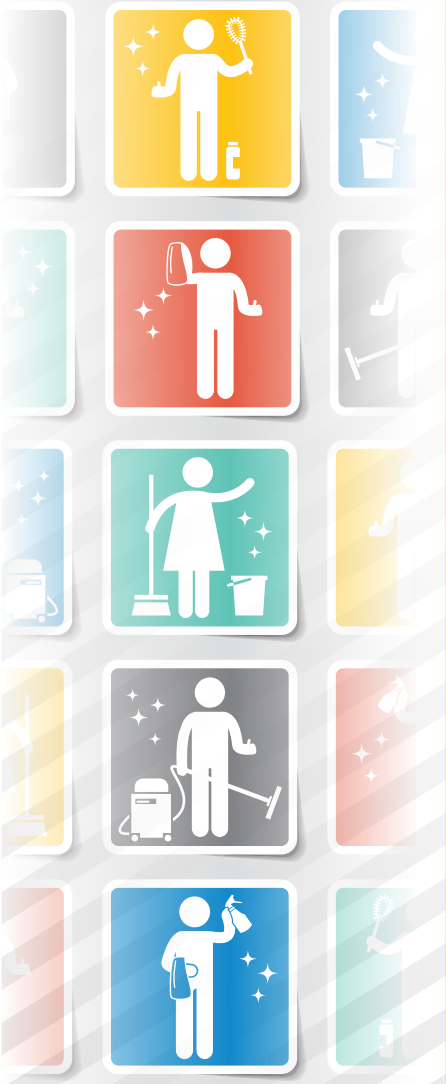

CHAPTER 2-000 PROVIDER PARTICIPATION

2-001 Provider Eligibility

2-001.01 Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department.

2-001.02 Eligibility: To be eligible to participate in the Nebraska Medical Assistance Program (NMAP), the provider shall meet the general standards for all providers in Chapters 1-000, 2-000, and 3-000 of this title, if appropriate, and the standards for participation for that provider type. The standards for participation are listed in each provider chapter of this title; in Title 480 NAC for home and community-based waiver services; and in Title 482 for managed care services. The Department shall not pay a provider who is required to be licensed and/or certified but who is not licensed and/or certified at the time of service.

2-001.02A Denial of Provider Agreement for Good Cause: The Department may refuse to execute, or may cancel, a provider agreement with a provider when there is demonstratable good cause. Good cause is, defined as but is not limited to -

1. The provider does not meet the standards for participation required by the Nebraska Medical Assistance Program (NMAP) which are listed in the appropriate chapter of Titles 471, 480, and/or 482 for each type of service; or
2. The provider, or an employee of the provider, has been excluded, sanctioned, or terminated from participation by Medicare or Medicaid in Nebraska or another state (see 471 NAC 2-002).

No provider agreement will be issued or remain in effect if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider or any other household members. The provider and household members shall not engage in or have a history of behavior injurious to or which may endanger the health or morals of the client.

2-001.03 Provider Agreements: Each provider is required to have an approved agreement with the Department. By signing the agreement, the provider agrees to -

1. 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;
2. Provide services according to the regulations and procedures of the Department for NMAP;
3. Provide services in compliance with Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973;

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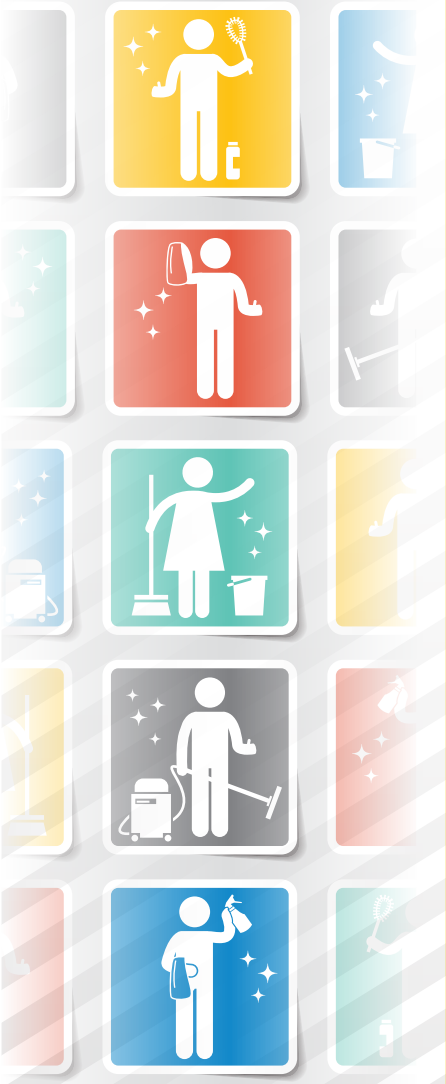

4. Accept as payment in full the amount paid in accordance with the rates established by the Department after all other sources (including third party resources, Medicare, or excess income) have been exhausted. Exception: If a client resides in a nursing facility, a payment to the facility for the client 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;
5. Submit charges to the Department which do not exceed the provider's charges to the general public;
6. Submit claims which are true, accurate, and complete;
7. 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;
8. Submit claims electronically, if applicable, under proper signature of the provider or the provider's authorized representative;
9. 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;
10. 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
11. A provider shall not establish a policy to automatically waive copayment 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.

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:

1. Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90);
2. Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91); or
3. 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.

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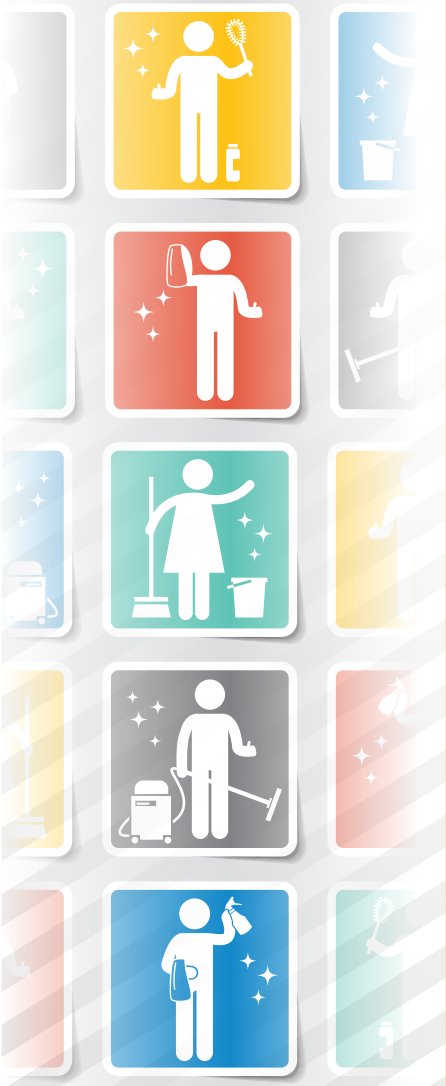

The Department does not accept provider agreements that have been altered in any way. An altered agreement will be returned to the potential/current provider; a new agreement will be required or participation in NMAP will be terminated.

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;
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.

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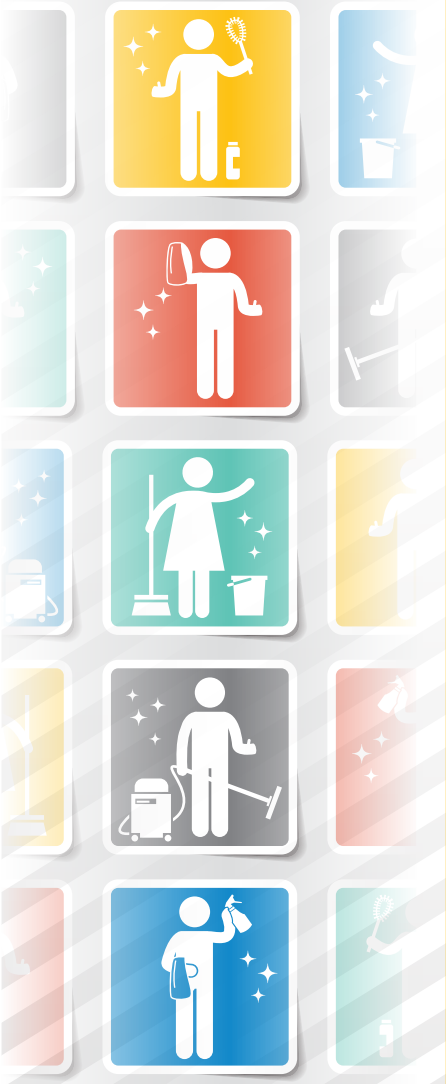

2-001.06 Principles of Providing Medical Assistance: Medical care and services are provided through NMAP to maintain good physical and mental health, to prevent physical disease and disability, to mitigate disease, and to rehabilitate the individual. The amount and type of service required is defined 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 -

1. Chapters 1-000, 2-000, and 3-000 of Title 471;
2. The appropriate provider chapter; and
3. Instructions for forms and electronic transactions.

While the handbooks contain policy related to specific provider groups, they may not contain all rules and regulations of NMAP for all possible circumstances. In these cases, regulations contained in the Nebraska Department of Health and Human Services Finance and Support Manual will prevail. The individual provider is responsible for ensuring that s/he has an up-to-date provider handbook, that s/he has all applicable rules and regulations, and that employees, consultants, and contractors are informed about the regulations of this program.

2-001.08 Provider Bulletins: The Medicaid Division may issue provider bulletins to inform providers of regulation interpretations.

2-001.09 Electronic Information Exchange: Any entity that exchanges standard electronic transactions with the Department must have an approved trading partner agreement with the Department.

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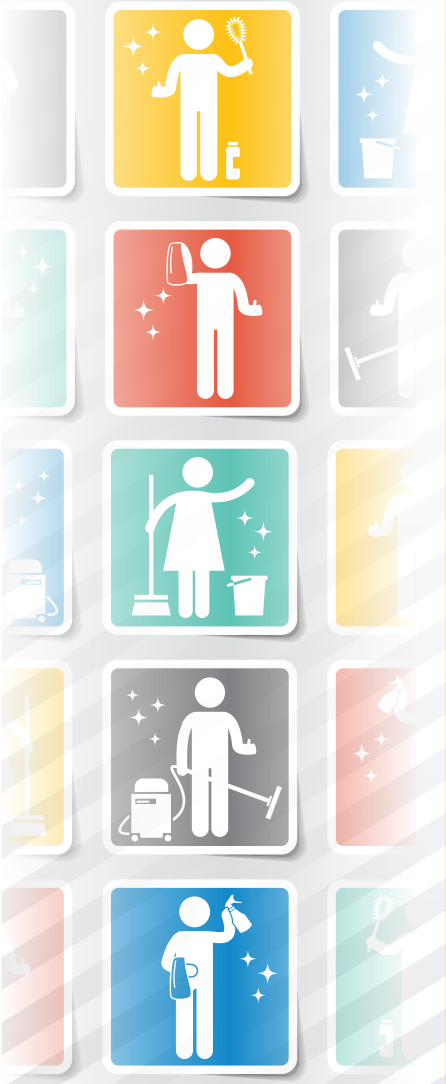

2-002 Administrative Sanctions

2-002.01 Purpose: This section -

1. Establishes the basis on which certain claims for NMAP services or merchandise will be determined to be false, fraudulent, abusive, or in violation of NMAP policies, procedures, and regulations;
2. Lists the sanctions which may be imposed; and
3. Describes the method of imposing the sanctions.

The Surveillance and Utilization Review (SURS) Unit in the Medicaid Division has responsibility for these functions.

2-002.02 Definitions: The following definitions apply within this section:

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Nebraska Medical Assistance Program (NMAP) or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. This may include under-utilization, lack of treatment, or lack of appropriate referrals. Abuse also includes client practices that result in unnecessary cost to NMAP.

Affiliates: Persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

Billing: Presenting, or causing to be presented, a claim for payment to the Department, its agents, or assignees.

Billing Agent: An entity that submits or facilitates the submission of claims for payment to the Department.

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

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

Closed-End Provider Agreement: An agreement that is for a specific period of time that must be renewed to allow the provider to continue to participate in NMAP.

Excluded Person: Any person who has been formally denied enrollment or continued participation in NMAP.

Exclusion: Denial of enrollment or continued participation in NMAP.

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Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Fraud includes, but is not limited to, the willful false statement or representation, or impersonation or other device, made by a client or applicant, provider, Departmental employee, or any other person, for the purpose of obtaining or attempting to obtain, or aiding or abetting any person to obtain -

1. An assistance certificate of award to which s/he is not entitled;
2. Any commodity, food stuff, food coupon, or payment to which the individual is not entitled or a larger amount of payment than that to which the individual is entitled;
3. Any payment made on behalf of a client of medical assistance or social services;
4. Any other benefit administered by the State of Nebraska, its agents or assignees; or
5. Assistance in violation of any statutory provision relating to programs administered by the Nebraska Department of Health and Human Services Finance and Support.

NHC: The Nebraska Health Connection (Medicaid managed care) (see Title 482 NAC).

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."

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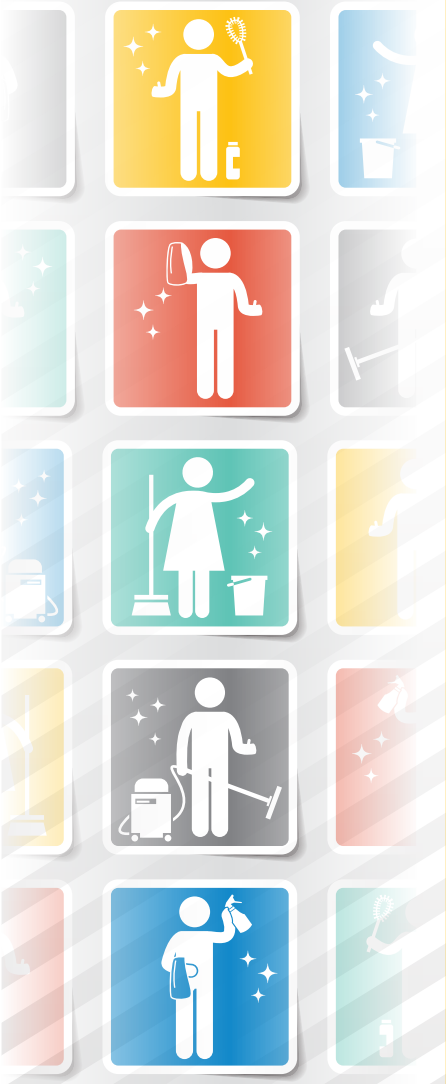

Suspension from Participation: An exclusion from participation in NMAP for a specified period of time.

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.

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;

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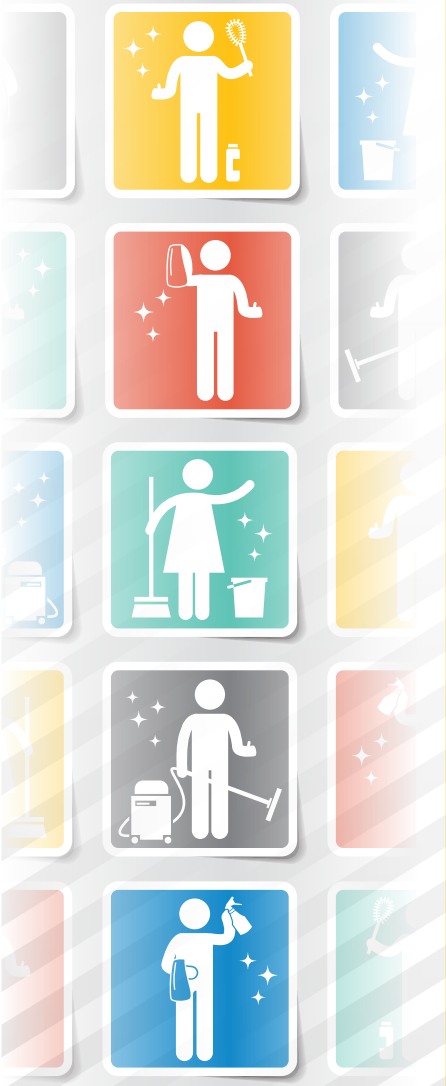

8. Breaching the terms of the Medicaid provider agreement or submitting false or fraudulent application for providing participation;
9. Violating any provision of the Nebraska laws regarding NMAP or any rule or regulation of NMAP;
10. Failing to comply with the terms of the provider certification on 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;
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;

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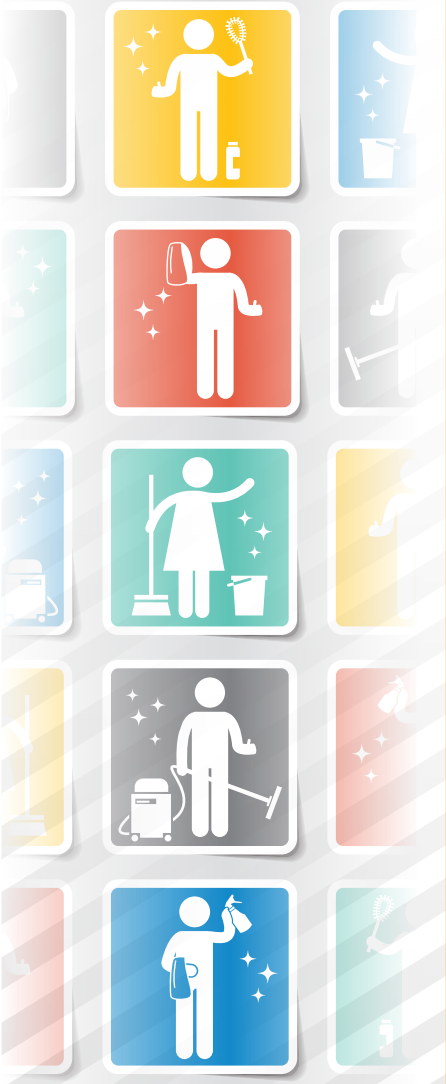

24. Submitting duplicate bills, including billing NMAP twice for the same service, or billing both NMAP and another insurer or government program;
25. Billing before the goods or services are provided or dispensed prior to the date of billing (pre-billing);
26. Any action resulting in a reduction or 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 or 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;
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.

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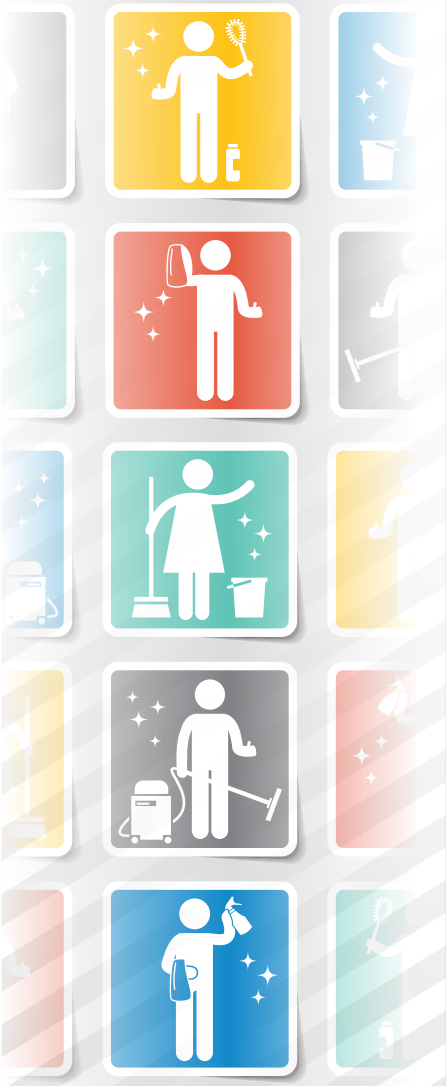

2-002.05 Imposition of a Sanction: The decision on the sanction to be imposed is at the discretion of the Director. The following factors are considered in determining the sanctions to be imposed:

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.

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.

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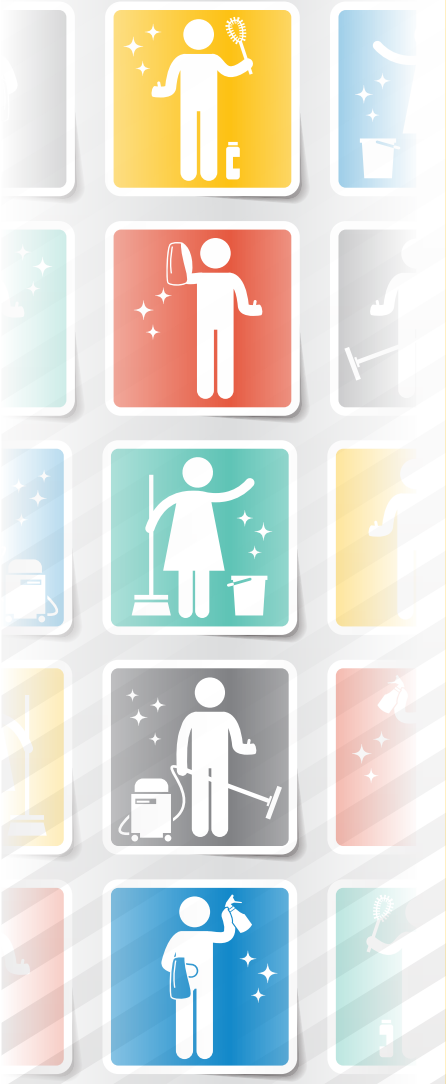

2-002.05B Sanction of Affiliates: The Department may sanction all known affiliates of a provider when each decision to include an affiliate is made on a case by case basis after considering all relevant facts and circumstances. The Department may determine the affiliate's violation, failure, or inadequacy 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.

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.

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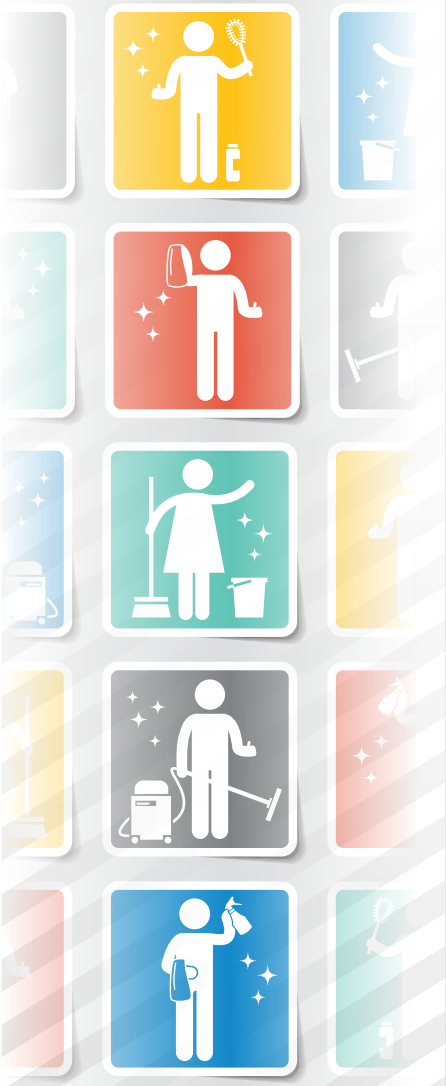

2-002.05H Denial of Enrollment: At the discretion of the Department, providers who have previously been terminated or suspended may or may not be re-enrolled as providers of Title XIX (Medicaid) services.

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. 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.

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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.

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.

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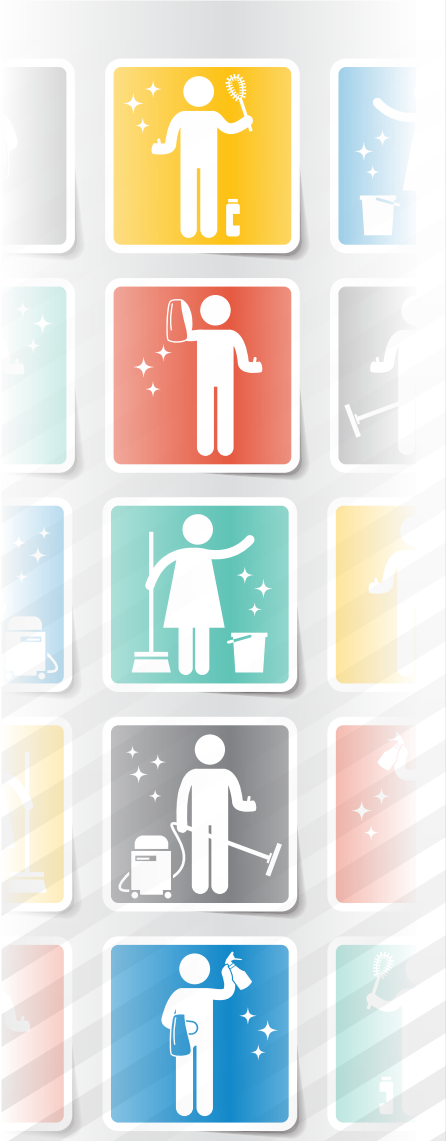

2-005 Advance Directives: An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (statutory or as recognized by the courts of the state) that relates to the provision of medical care if the individual becomes incapacitated.

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;
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.

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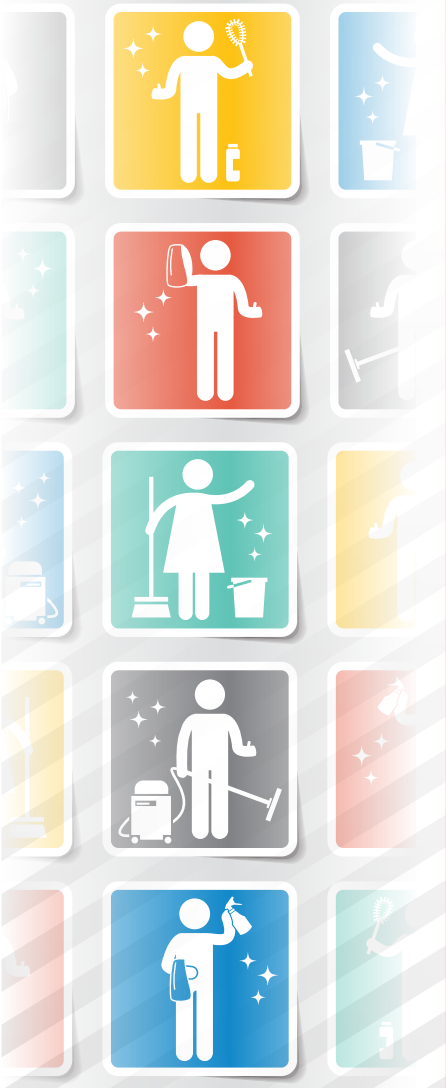

2-005.01 When Providers Give Information Concerning Advance Directives: Providers shall give information concerning advance directives to each adult patient as follows:

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 s/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 s/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 s/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.

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.

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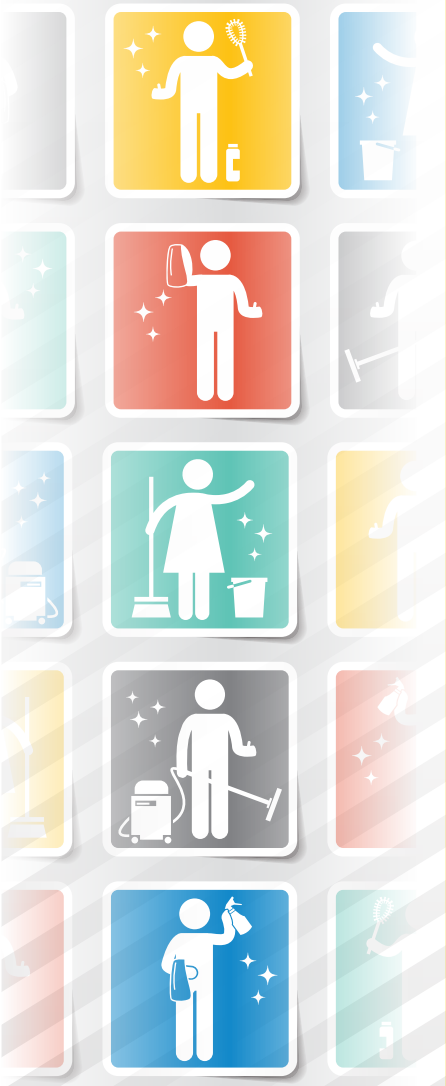

2-006.02 Business Transactions: When requested, providers shall disclose, within 35 days of the date on the request, full and complete information on -

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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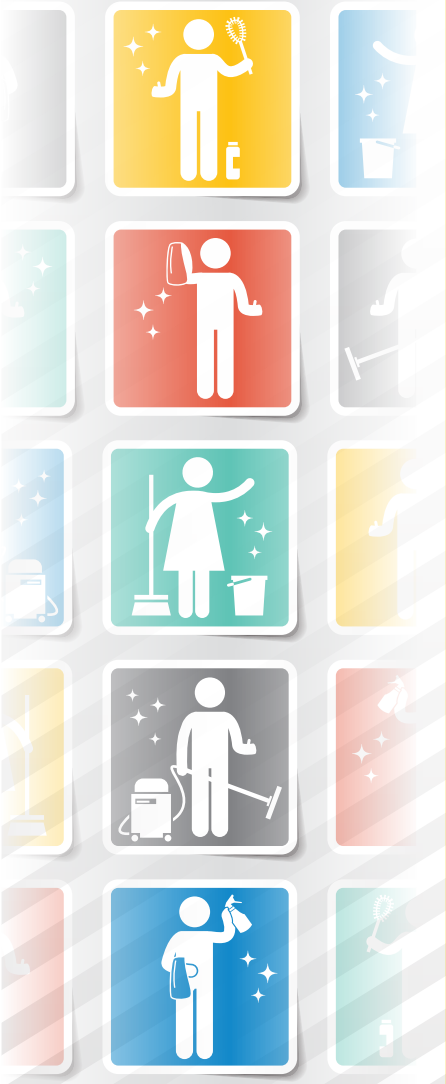

REV. JULY 2, 2013 NEBRASKA DEPARTMENT OF MEDICAID SERVICES
MANUAL LETTER # 54-2013 HEALTH AND HUMAN SERVICES 471 NAC 3-000

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.

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:

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);

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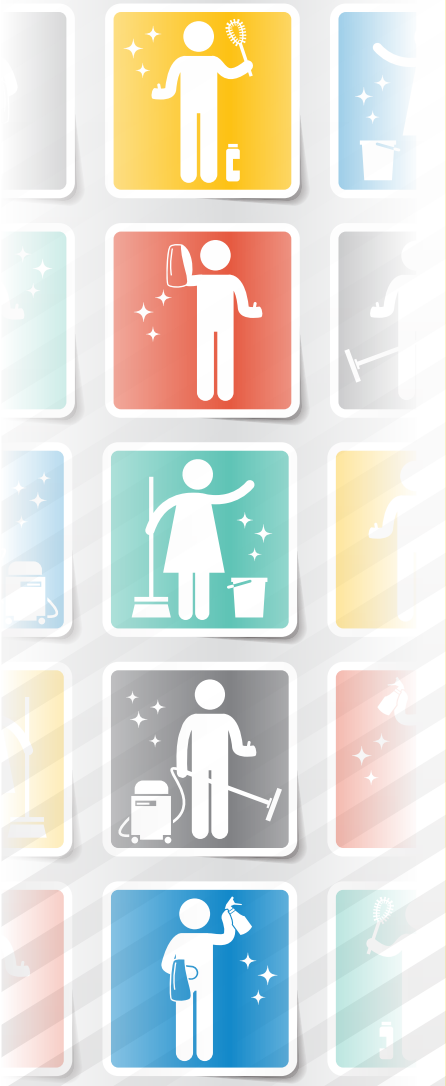

4. The medical care and services are within the guidelines of Medicaid;
5. The client's case record must contain information to meet state requirements; and
6. A trading partner agreement has been approved, if required, for clearinghouses, billing agents, and providers submitting claims using electronic 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;
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.

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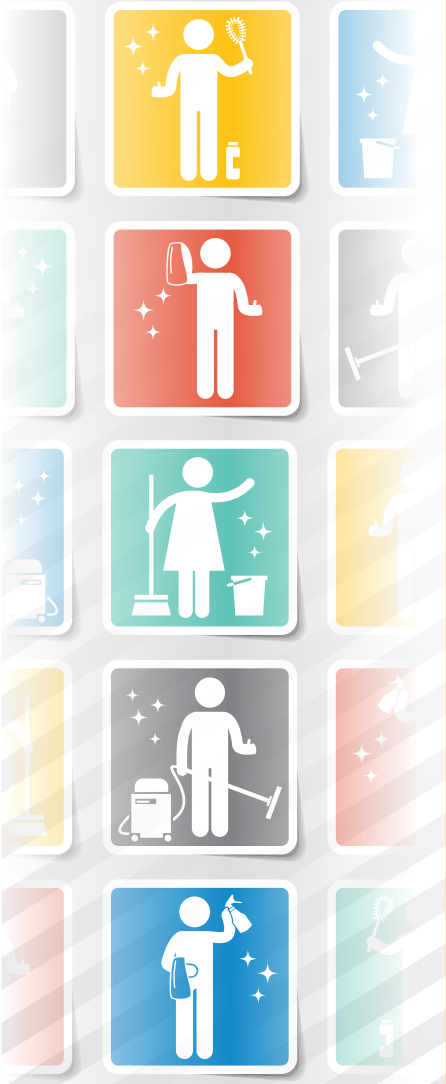

3-002.01D Provider's Failure to Cooperate in Securing Third Party Payment: The Department may deny payment of a provider's claims if the provider fails to apply third party payments to medical bills, to file necessary claims, or to cooperate in matters necessary to secure payment by insurance or other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

3-002.02 Payment

3-002.02C 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.

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.

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.

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.

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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 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.

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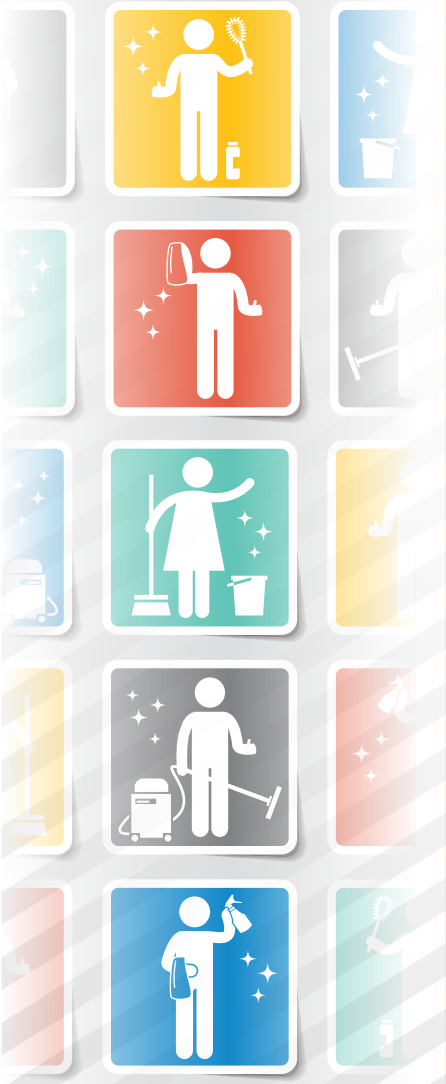

3-002.10 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"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.

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

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

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:

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.

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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 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.

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.

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 s/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.

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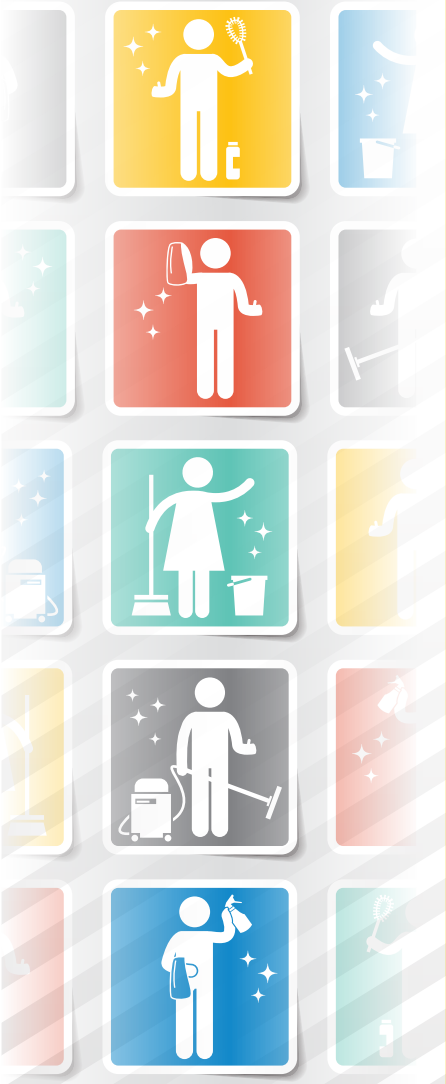

Cost Avoidance: A method of adjudicating claims as payor of last resort in order to utilize all third party resources before Medicaid payment can be made.

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.

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.
>
> 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).

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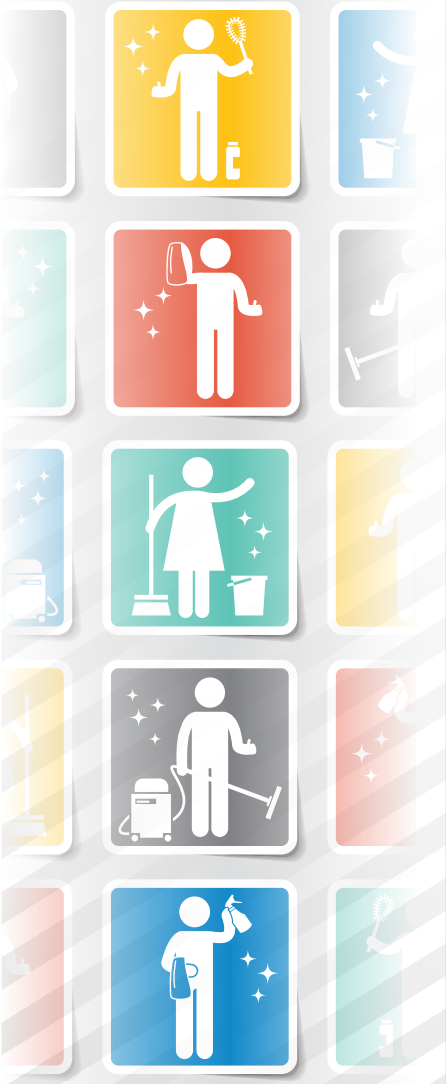
SECTION 6 ATTACHMENT H

Department of Health & Human Services
DHHS
NEBRASKA



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 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 preauthorization 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.

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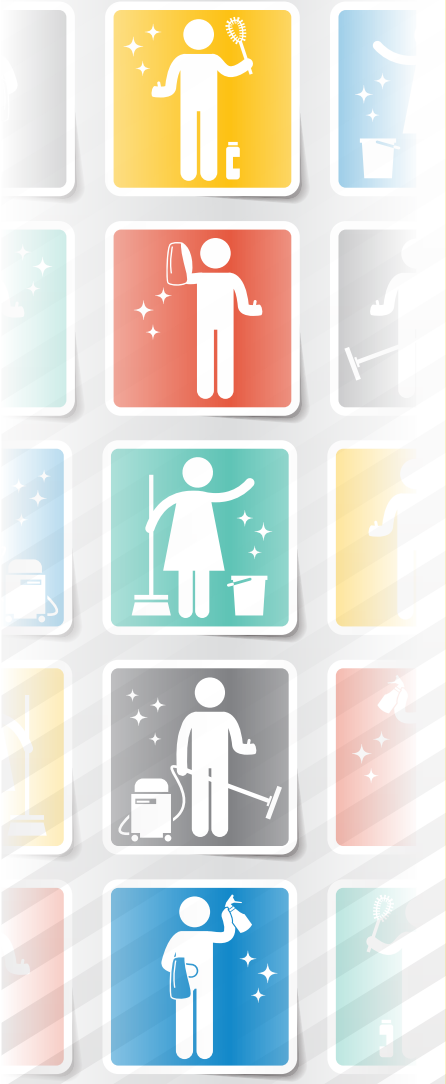

3-005 Prior Authorization: The Department is responsible for ensuring the appropriate expenditure of NMAP funds for medically necessary services provided to eligible clients. Prior authorization of payment for specific covered services, as a utilization control tool, is one method used to meet this responsibility. 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;
5. Promote the most effective and appropriate use of available services and facilities; and
6. Eliminate misutilization 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.

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