TITLE 181 SPECIAL HEALTH PROGRAMS

CHAPTER 1 NEBRASKA CHRONIC RENAL DISEASE PROGRAM

1-001 SCOPE AND AUTHORITY: These regulations govern the Nebraska Chronic Renal Disease Program established by Neb. Rev. Stat. §§ 71-4901, 71-4903, and 71-4904. The regulations implement Neb. Rev. Stat. §§ 71-4903 by setting standards for client eligibility and participation.

1-002 DEFINITIONS:

Adequate Notice means a notice from the Department mailed at least ten days before the effective date of the action(s) that states the action(s) to be taken, the reason(s) for the intended action(s), and the specific regulation that supports or requires the action(s).

Chronic Kidney Disease – also known as Chronic Renal Disease – is the slow loss of kidney function over time. End-Stage Renal Disease (ESRD) is the final stage of chronic kidney disease.

Client means an individual applying for or receiving assistance from the Program.

Department means the Nebraska Department of Health and Human Services.

Deprived means that an individual within two years of applying for assistance from the Program has not directly or indirectly given away or sold property for less than fair market value for the purpose of qualifying for assistance.

Explanation of Benefits is an insurance company's written explanation regarding a claim showing what it paid on a client's behalf. May also be called a remittance advice.

Program means the Nebraska Chronic Renal Disease Program, administered by the Nebraska Department of Health and Human Services for the purpose of assisting clients.

1-003 CLIENT ELIGIBILITY AND APPLICATION

1-003.01 Client Eligibility. To be eligible for the Chronic Renal Disease Program, an individual must:

1. Be diagnosed with chronic kidney disease.
2. Require dialysis or kidney transplantation to maintain or improve his/her condition.
3. Meet income guidelines based on household size.
4. Meet citizenship/alien status and Nebraska residency requirements.
5. Affirm that s/he has not deprived him or herself of property.
6. Meet the statutorily defined standards for being served by the Program.

1-003.01A An individual who has received a kidney transplant must have been a Program client prior to receiving the transplant and must be within three years of receiving the transplant in order to be served by the Program.

1-003.01B All individuals eligible for the Program must first apply for and accept any Medicaid benefits for which they may be eligible and benefits from any other programs, including any third-party payment, to the maximum extent possible.

1-003.01C Income Guidelines. A client's annual income must be at or below three-hundred (300) percent of the federal poverty level in order to participate in the Program. The income level is adjusted based on household size.

1-003.01Ci Proof of income sources and household size are defined in the Program's Policy for Determining Income Verification and Household Size.

1-003.01D For the purpose of determining eligibility for the Program, the Department applies the citizenship/alien status requirements from Neb. Rev. Stats. §§ 4-108 through 4-114.

1-003.02 Client Application. Application to the Program is made through the staff at the licensed health clinic where the client receives dialysis.

1-003.02A A Department approved application is used in applying for the Program. As part of the application process, at a minimum, clients are required to provide the following:

1. Contact and identifying information.
2. Income-verifying and household information.
3. Insurance information.
4. Medical certification that verifies the individual requires dialysis or kidney transplantation to maintain or improve his/her condition.
5. Proof of United States citizenship/alien status and Nebraska residency.
6. Affirmation that the individual meets the Program's statutorily defined standards.

1-003.02B Approval. An approved application establishes client eligibility for seven years, provided the client continues to meet the eligibility requirements in 181 NAC 1-003.01. When the Department determines an individual meets the eligibility requirements to participate in the Program, the Department must send written notice to the client stating s/he has been approved for participation in the Program and the service start and end dates.

1-003.02Bi Service Start Date. The service start date for a client is the first day of the month in which the complete Department approved application is received by the Program. The service start date may be adjusted upon the discretion of the Department.

1-003.02C Denial. When the Department determines an individual does not meet the eligibility requirements in 181 NAC 1-003.01, the Department must send written notice to the individual stating the reason for the denial.

1-003.03Ci Re-application. To re-apply after a denial, a new application is required.

1-003.03 The Program will not authorize payment for any services prior to the client's service start date.

1-004 MAINTENANCE OF CLIENT ELIGIBILITY

1-004.01 Changes in Client Status. The client, or the client's representative, is responsible for informing the Program, in writing, within thirty (30) days of the following changes:

1. When the client's annual income increases above three hundred (300) percent of the federal poverty level.
2. In the number of persons living in the home,
3. To the treatment status – including whether or not the client is still receiving dialysis, has had a kidney transplant, or has died.
4. To the client's residency status – including whether the client has moved out-of-state.
5. To the client's permanent home address and primary phone number.

Failure to inform the Program of changes to the client status is grounds for terminating the client from the Program.

1-004.02 Renewal Applications. A new Department approved application must be submitted for each active client every seven years calculated from the service start date stated in the client eligibility letter.

1-004.02A The client works with staff at the licensed health clinic to submit the renewal application.

1-004.02B When due, the renewal application must be received by the Program within sixty (60) days of the service end date noted on the client eligibility letter.

1-004.02C The Program will notify the client of his/her eligibility status.

Failure to submit a renewal application when due shall result in the termination of the client from the Program.

1-005 BENEFITS

1-005.01 Covered Services. The Program will assist in paying for the following services that are directly related to the care and treatment of chronic kidney disease:

1-005.01A Pharmaceutical products listed on the Program's Reimbursable Drug Formulary.

1-005.01B Dialysis procedures listed on the Program's Reimbursement Procedures for Dialysis Services. Procedures must be provided through a licensed health clinic as described in 175 NAC 7.

1-005.02 Services Must Be Prescribed. All services must be prescribed by a licensed health care provider possessing appropriate specialized knowledge in the diagnosis and treatment of chronic kidney disease.

1-005.03 Non-covered Services. The Program does not cover:

1-005.03A Any service denied by Medicare, Medicaid or any other health insurance as not medically necessary for the individual client.

1-005.03B Any service related to the treatment of diabetes or other non-renal related conditions.

1-005.03C Post-kidney transplant immunosuppressant (anti-rejection) drugs.

1-005.03D Services which are investigative or experimental.

1-006 LIMITATIONS

1-006.01 Client Assistance. The annual amount paid by the Program on behalf of any one client will not exceed one and one-half percent (1.5%) of the amount allocated to the Program by the Nebraska Legislature for that state fiscal year. This amount may be adjusted upon the discretion of the Department based on the availability of funds and the number of clients served by the Program.

1-006.01A A client will be given adequate notice that s/he has met his/her annual Program allotment.

1-006.01B Service costs not covered by the Program after all other available insurance resources have determined and paid their share are the responsibility of the client.

1-006.02 Out-of-State Services. Only out-of-state dialysis service providers or pharmacies that have signed a Program Service Provider Enrollment Form may provide covered services and claim payment from the Program.

1-006.02A If a client lives near the border between Nebraska and another state, and the nearest – within fifty (50) miles – dialysis service provider or pharmacy is in another state, the client may receive services at that out-of-state facility.

1-006.02B Out-of-state dialysis and pharmacy services are available within the Program's budgetary limitations as described in 181 NAC 1-006.01.

1-006.03 Payer of Last Resort. The Program is the payer of last resort. Primary insurance providers (private, Medicaid or Medicare) must be invoiced first and have paid on a client's behalf before an invoice is sent to the Program for payment consideration.

1-006.04 Termination from the Program. Clients are no longer eligible for the Program under the following circumstances:

1-006.04A Clients who stop dialysis treatments will be terminated from the Program twelve (12) months after the month in which the course of dialysis is terminated.

1-006.04B Clients who receive a kidney transplant and no longer require dialysis will be terminated from the Program thirty-six (36) months after the month in which the kidney transplant is received.

1-006.04C If a client's annual income exceeds three-hundred (300) percent of the federal poverty level s/he is terminated from the Program.

1-006.04D If the client moves out-of-state s/he is terminated from the Program effective the date of the move.

1-006.04E Misrepresentation on the part of a client.

1-006.04F Upon death.

1-006.05 Client Inactivity. If there have been no payments for pharmaceutical or dialysis services processed on a client's behalf in one year – calculated from the start of each state fiscal year – the client's participation in the Program shall be terminated.

1-007 PROVIDER REQUIREMENTS AND PAYMENTS

1-007.01 Participation Standards. To participate in the Program, service providers must be licensed by the Department, or its equivalent in another state.

1-007.01A Service providers must complete and sign the Program's Service Provider Enrollment Form prior to participating with the Program. Providers not meeting the standards of the Provider Enrollment Form are not eligible to participate with the Program.

1-007.02 Pharmaceutical Payment. Only pharmaceutical products listed on the Program's Reimbursable Drug Formulary are covered by the Program.

1-007.02A Payments are made in accordance with the Provider Standards noted in the Program's Service Provider Enrollment Form and following the Approval and Payment procedures outlined in 181 NAC 1-008.

1-007.02B Invoicing procedures are outlined in the Program's Reimbursement Procedures for Pharmacies. Invoicing procedures may be adjusted upon the discretion of the Department.

1-007.02C Payer of Last Resort. The Program is the payer of last resort. Primary insurance providers (private, Medicaid or Medicare) must be invoiced first and have paid on a client's behalf before an invoice is sent to the Program for payment consideration.

1-007.02D If the client has prescription drug insurance coverage, the Program reimburses the portion that is the client's responsibility. This may be adjusted upon the discretion of the Department.

1-007.02E If the client is responsible for paying the cost of the drug at the time it is dispensed, the payment amount is based on Nebraska Medicaid fee for service allowable cost.

1-007.02Ei The remaining cost after the Program has paid is the responsibility of the client.

1-007.02F Payment is subject to the limitations in 181 NAC 1-006.

1-007.03 Dialysis Service Payment. The Program pays up to fifty (50) percent of the client co-pay after all other insurances or third-party payers have paid their share. The payment percentage may be adjusted upon the discretion of the Department.

1-007.03A Payments are made in accordance with the Provider Standards noted in the Program Service Provider Enrollment Form and following the Approval and Payment procedures outlined in 181 NAC 1-008.

1-007.03B Payer of Last Resort. The Program is the payer of last resort. Primary insurance providers (private, Medicaid or Medicare) must be invoiced first and have paid on a client's behalf before an invoice is sent to the Program for payment consideration.

1-007.03C Invoicing procedures are outlined in the Program's Reimbursement Procedures for Dialysis Services, Invoicing procedures may be adjusted upon the discretion of the Department.

1-007.03D The remaining dialysis service cost after the Program has paid is the responsibility of the client.

1-007.03E Payment is subject to the limitations in 181 NAC 1-006.

1-007.04 The Program makes payment on behalf of a client directly to the service provider or pharmacy.

1-008 APPROVAL AND PAYMENT

1-008.01 Payment Approval. Payment for pharmaceuticals and dialysis services must be approved by the Department. Payment is subject to the limitations in 181 NAC 1-006. Claims will be approved for payment when all of the following conditions are met:

1-008.01A A Program Service Provider Enrollment Form is on file with the Department for the entity claiming payment.

1-008.01B The client was approved for participation in the Program when the service was provided.

1-008.01C The services provided are for Program covered services as described in 181 NAC 1-005.

1-008.01D No more than six months have elapsed from the date of service until when the claim is received by the Program.

1-008.01Di Payment may be made by the Department for claims received more than six months after the date of service if the circumstances which delayed the submittal were beyond the provider's control. An example of a circumstance considered by the Department to be beyond the provider's control is third-party liability situations. The Department shall determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

1-008.02 Provider's Failure to Cooperate in Securing Third-Party Payment. The Program may deny payment of a provider's claims if the provider fails to: apply third-party payments to covered services, file necessary claims, or cooperate in matters necessary to secure payment by insurance or other responsible third-parties.

1-008.02A Third-Party Payment means any firm, partnership, corporation, company, association or any other entity responsible for, or otherwise under an obligation to provide, the payment of all or part of the cost of the care and treatment of a person with chronic kidney disease.

1-008.02B Third-Party Liability Refunds. Whenever a service provider receives a third-party liability payment after a claim has been paid by the Department, the provider shall refund the Department for the full amount within thirty (30) days. The refund must be accompanied by a copy of the documentation, such as the Explanation of Benefits or electronic coordination of benefits.

1-009 RIGHT TO A FAIR HEARING

1-009.01 Right to a Fair Hearing. If a client is denied services, has his/her case terminated or believes the Program acted erroneously, s/he may request a fair hearing. The request must be in writing and filed with the Department within thirty (30) days of the mailing date on the written notice from the Department. The request must:

1. Include a brief summary of the Department's action being challenged;
2. Describe the reason for the challenge; and
3. Be sent to the Director of the Nebraska Department of Health & Human Services, Division of Public Health.

The fair hearing process is conducted in accordance with 184 NAC 1.

Title 181 - NEBRASKA DEPARTMENT OF HEALTH

Chapter 1 - STANDARDS GOVERNING CARE AND TREATMENT OF PERSONS SUFFERING FROM CHRONIC RENAL DISEASE

001 DEFINITIONS AND BASIS REQUIREMENTS

001.01 Definitions. As used in these standards, unless the context to be intelligible or to prevent absurdity otherwise requires:

001.01A Irreversible, far-advanced renal failure, or so-called chronic renal disease, is defined as that stage of renal functional impairment which can no longer be favorably influenced by conservative management and which requires dialysis (hemo- or peritoneal) or transplantation to maintain life and health. The diagnosis of chronic renal disease may need to be established or confirmed through: (a) the distinction between acute reversible renal insufficiency and chronic renal disease; (b) the exclusion of certain chronic systemic or localized disorders of the extrarenal or intrarenal vasculature, renal parenchyma or urinary excretory system which might be corrected by medical or surgical treatment; (c) the observation and monitoring of the patient with progressive loss of renal function from renal disease of known or unknown etiology, with demonstrated failure of the process to stabilize or improve despite all reasonable and appropriate therapy.

001.01B Department shall mean the Department of Health of the State of Nebraska.

001.01C Patient shall mean a person suffering from a chronic renal disease who requires life saving care and treatment for such renal disease, but who is unable to pay for such services on a continuing basis and participates in the Nebraska Chronic Renal Disease Program.

001.01D Program shall mean the Nebraska Chronic Renal Disease Program, formulated and administered by the Nebraska Renal Disease Advisory Committee and the Department of Health of the State of Nebraska for the purpose of assisting persons suffering from chronic renal disease who require life saving care and treatment for such renal disease but who are unable to pay for such services on a continuing basis.

001.01E Third Party Payer shall mean any individual, firm, partnership, corporation, company, association or any other entity responsible for, or otherwise under an obligation to provide, the payment of all or part of the cost of the care and treatment of a person suffering from chronic renal disease; but such term shall not mean the person suffering from chronic renal disease himself, any health care practitioner or facility providing services to such person, or the Department of Health.

001.02 Basic Requirements. An individual suffering from chronic renal disease, in order to be eligible to participate in the Nebraska Chronic Renal Disease Program, must meet the following basic requirements:

001.02A He must be a bona fide resident of the State of Nebraska.

001.02B He must not be able to pay the total cost of such needed care and treatment without depriving himself or those legally dependent upon him for their necessities of life.

001.02C He shall not have deprived himself, directly or indirectly, of any property for the purpose of qualifying for assistance.

001.02D He shall not have relatives legally responsible to provide such care and treatment who refuse or neglect to provide such care and treatment in whole or in part without good cause.

001.02E He must be a proper candidate for such care and treatment, including being willing to receive such care and treatment.

Such person must also comply with the specific requirements of these standards.

002 TREATMENT FACILITIES

002.01 General. There shall be an integrated Nebraska Chronic Renal Disease Program which shall provide patient care and treatment through Renal Transplant Centers, Renal Disease Centers, Renal Dialysis Satellites, Limited Care Dialysis Facilities, and Home Dialysis Programs. These components of the Nebraska Renal Dialysis Program shall be subject to the approval and quarterly review of the Renal Disease Advisory Committee. Consultation with the Comprehensive Health Planning Agency is required.

002.02 Home Dialysis

002.02A Definition. Home Dialysis shall mean a mode of renal dialysis performed at the patient's place of residence. Home dialysis is recognized as an effective method of treatment and should be

implemented whenever the patient's condition and history indicate that a Home Dialysis Program is desirable.

002.02B Training Center. A Dialysis Training Center will be designated by the Renal Disease Advisory Committee after individual review of staffing, space, equipment and expertise required to carry out an ongoing Home Dialysis Training Program.

002.02C Operation. A Home Dialysis Program shall be carried out only in conjunction with a Dialysis Training Center. Equipment and supplies must be prescribed by the director of the Dialysis Training Center, subject to approval by the Renal Disease Advisory Committee.

002.02D Responsibility for Patients. The director of a Dialysis Training Center shall assume responsibility for all home dialysis patients and shall certify patients for home dialysis with the approval of the Renal Disease Advisory Committee.

002.02E Records. Records of each patient's course of treatment must be kept by the Dialysis Training Center and are subject to the quarterly review of the Renal Disease Advisory Committee.

002.03 Limited Care Dialysis Facility

002.03A Definition. A Limited Care Dialysis: Facility shall mean a facility which provides an alternative to hospital dialysis and which provides minimal care to patients who cannot maintain a home dialysis program.

002.03B Supervision of Patients. A Limited Care Dialysis Facility shall provide minimum care and supervision of patients who are determined to be suitable for this mode of treatment.

002.03C Operation. A Limited Care Dialysis Facility shall be operated only in conjunction with a Renal Disease Center. Each Limited Care Dialysis Facility and its personnel must be approved by the director of a Renal Disease Center and by the Renal Disease Advisory Committee. Applications shall be considered on an individual basis.

002.03D Review of Patients. A periodic review of each patient's course of treatment shall be completed in conjunction with a Renal Disease Center. A quarterly report shall be made to the Renal Disease Advisory Committee.

002.04 Renal Dialysis Satellite

002.04A Definition. A Renal Dialysis Satellite shall mean a hospital facility which provides necessary renal dialysis treatment in or near

a patient's home community when it is not feasible for the patient to receive treatment in a Renal Disease Center.

002.04B Relationship to Center. Each Renal Dialysis Satellite will be evaluated on an individual basis. It must function in a close working relationship with an approved Renal Disease Center whose director shall assume responsibility for maintaining standards. Responsibility shall be delegated to a physician selected on an individual basis according to local circumstances.

002.04C Commitment. There must be a definite, written commitment from the Satellite's hospital administration for adequate space and appropriate salaries for personnel required for an ongoing program for no less than a three-year period in order to be approved.

002.04D Equipment and Methodology. The equipment and methodology for satellite dialysis must meet the approval of the Renal Disease Advisory Committee. A protocol detailing standards, goals, and means of internal review and assessment of the patient's progress must be available. Participating satellites must submit quarterly reports for review by the Renal Disease Advisory Committee.

002.05 Renal Disease Center

002.05A Definition. A Renal Disease Center shall mean a unit established within, affiliated with, or existing as a part of a hospital duly licensed by the Department of Health or a federal hospital accredited by the Joint Commission on Hospital Accreditation and which has demonstrated a high level of competence in relevant medical and technical disciplines regarding renal dialysis. In the designation of a Renal Disease Center, the following factors shall be considered: the number of patients to be served, the geographic location, and the influence of these factors upon the cost and quality of care.

002.05B Director. The director of a Renal Disease Center shall be a qualified medical specialist with a major continuing professional commitment to the care and treatment of renal disease and who has had appropriate training or equivalent experience in nephrology.

002.05C Personnel. The personnel of a Renal Disease Center shall consist of a term of qualified medical specialists. For example, there must be trained specialists for the sequential assessment of patients with progressive renal failure to perform, among other evaluations, urologic, psychiatric, hematologic, neurologic and endocrine studies as well as necessary histopathologic techniques for renal biopsy interpretation. Other members of the team shall include persons skilled in dialysis techniques, social service, and dietetics.

002.05D Commitment. There must be a definite, written commitment from the Center's hospital administration for adequate space and appropriate salaries for dialysis personnel for no less than a three-year period in order to be approved.

002.05E L Equipment and Methodology. The equipment and methodology for dialysis shall be optional but must be of a nationally recognized quality. A protocol for their use should be prepared and available for review by the Renal Disease Advisory Committee. This protocol should include standards, goals, and a formal means of internal review and assessment of the patient's progress.

002.05F Record Keeping. The record keeping techniques of the dialysis center shall be available for review; participating institutions must agree to submit all appropriate medical records to the Renal Disease Advisory Committee for quarterly review.

002.05G Center Responsibilities. A Renal Disease Center shall be capable of providing all physical facilities, professional consultation, personal instruction, medical treatment and care, drugs, dialysis equipment, and supplies necessary for the carrying out of a medically sound renal dialysis program, as well as the proper training and supervision of medical and supporting personnel.

002.05H Services to Sub-Units. A Renal Disease Center shall provide all required medical, professional, and administrative assistance and supervision to the Renal Dialysis Satellites, Limited Care Dialysis Facilities, and Home Dialysis Programs as designated by the Renal Disease Advisory Committee.

002.06 Renal Transplant Center

002.06A Definition and Purpose. The Nebraska Chronic Renal Disease Program recognizes that transplantation is the most desirable method of treatment for most renal patients. Therefore, the Renal Disease Advisory Committee, after careful review, shall designate a Renal Transplant Center, the primary purpose of which will be to expedite ultimate transplantation. The Transplantation Center shall be established within, affiliated with, or existing as a part of a hospital duly licensed by the Department of Health or a federal hospital accredited by the Joint Commission on Hospital Accreditation.

002.06B Evaluation and Re-evaluation of Patients. Primary emphasis will be placed in evaluation of patients for transplant. Evaluation and tissue-typing of each patient should be carried out by the Transplant Center as soon as possible. Re-evaluation should occur quarterly to insure that the Transplant Center is aware of the patient's progress.

002.06C Requirements. Generally a Transplant Center shall provide the following:

002.06C1 All diagnostic and treatment facilities for patients wit forms of kidney disease.

002.06C2 Acute hemodialysis facilities for pre-transplant and post-transplant treatment.

002.06C3 Consultative services to provide for all problems related to transplantation and treatment of patients with end-stage renal disease.

002.06C4 Tissue-typing laboratory with appropriate space and resources to perform required histocompatibility testing and crossmatch.

002.06C5 An organ procurement system capable of procuring an adequate number of organs for the transplant program.

002.06C6 An organ preservation program.

002.06C7 An adequately equipped operating room and a care unit capable of monitoring the transplant patient.

002.06C8 Staffing and expertise sufficient to carry out the transplant program as determined by the Renal Disease Advisory Committee.

003 MEDICAL CRITERIA FOR PATIENT SELECTION

003.01 Medical Eligibility Determination. Medical eligibility of a patient for selection as a participant in the Nebraska Chronic Renal Disease Program, the purpose of which is to assist in the care and treatment of persons suffering from chronic renal disease, shall be determined by a qualified medical specialist who is treating the patient and who certifies that the patient meets the criteria for Chronic Renal Disease as defined in part 001.01A. The physician shall agree to accept responsibility for the medical supervision and coordination of the patient's care and shall also agree to periodic reports as requested by the Department. All cases shall be subject to approval and continuous review by the Renal Disease Advisory Committee and may be considered on an individual basis.

003.02 Rejected Renal Transplants. Patients who have rejected renal transplants will be accepted for care by means of either long-term daily or short-term care while awaiting another kidney so long as all of the criteria outlined in section 003 are met.

Title 181
Chapter 1

004 PATIENT FINANCIAL ELIGIBILITY

004.01 Committee Review. Patient financial eligibility criteria shall be under continuous study and review by the Nebraska Renal Disease Advisory Committee and the Department, and revisions will be made to section 004 when necessary. When there is difficulty in determining patient financial eligibility, the case should be presented to the Nebraska Renal Disease Advisory Committee or a designated subcommittee for review and recommendation.

004.02 Limitation on Assistance. The Department will assist patients, within budget limitations, who are unable to pay for their own care in whole or in part, pursuant to the following income, estate, and patient participation tables:

Number in Family	1	2	3
Total Annual Income of no more than (Standard Budget Allowance):	$6,300	8,300	$9,200
(For families of more than 6, add $400 for each additional member.)	4 $10,000	5 $10,800	6 $11,300

STANDARD BUDGET ALLOWANCE

Amount over Adjusted Needs	Amount of Patient Participation
0 -99	00.00
100 -199	20.00
200 -299	40.00
300 -399	60.00
400 -499	80.00
500 -599	105.00
600 -699	130.00
700 -799	160.00
800 -899	190.00
900 -999	220.00
1000 - 1099	250.00
1100 - 1199	290.00
1200 - 1299	325.00
1300 - 1399	365.00
1400 - 1499	410.00
1500 - 1599	450.00
1600 - 1699	495.00
1700 - 1799	530.00
1800 - 1899	595.00
1900 - 1999	645.00
2000 - 2099	700.00
2100 - 2199	755.00

Amount over Adjusted Needs	Amount of Patient Participation
$2200 - 2299	$810.00
2300 - 2399	870.00
2400 - 2499	935.00
2500 - 2599	995.00
2600 - 2699	1060.00
2700 - 2799	1130.00
2800 - 2899	1200.00
2900 - 2999	1270.00
3000 - 3099	1345.00
3100 - 3199	1402.00
3200 - 3299	1495.00
3300 - 3399	1575.00
3400 - 3499	1660.00
3500 - 3599	1740.00
3600 and over	Fifty Percent (50%)

The above patient participation table shall be used as a minimum; Income Criteria may be adjusted according to the cost of living.

004.03 Medical Fees. All fees paid by the Department for medical and related charges for services to participants in the program shall not exceed the following fee schedule:

Institutional Dialysis	$198.00
Home Dialysis	90.00
Training Dialysis	220.00 (limited to six weeks)

All medical services must be prescribed, before authorized and performed, by a licensed practicing physician possessing appropriate specialized knowledge in the diagnosis and treatment of renal disease.

004.04 Patient Resources - Exclusions. The following exclusions shall be made concerning a patient's resources:

004.04A Personal property such as income-producing equipment, inventory of a small business, or tools should not be considered a resource if such property is needed to produce income during or following rehabilitation services.

004.04B Ownership of residence and contiguous land will be regarded as the patient's homestead and will not be considered a resource.

004.04C Personal property such as household furniture, life insurance policies, and an automobile should not be considered in determining economic need.

004.04D Property should not be considered as a resource when it represents an income-producing enterprise and the net income derived therefrom is within the normal living requirements.

004.05 Third Party Payers. The Department shall not pay for any patient care or treatment to the extent that assistance is available through other sources - public or private - or that third party payers are required to provide the same.

SOURCE: Section 71-4903(1)