NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

April 15, 2021
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 877-399-1398; Participant code: 3213662#

The purpose of this hearing is to receive comments on the adoption, amendment, and repeal of the following regulations:

The following regulation is proposed for ADOPTION:

467 NAC 3 – *Diagnoses and Services for the Medically Handicapped Children's Program*

The proposed new chapter will move the relevant portions of the regulations currently found in 467 NAC 4. The adoption of this new chapter will remove certain details regarding out-of-state services, transportation, and adaptive equipment; streamline the organization of diagnoses; and remove directions for agency staff.

The following regulation is proposed for REPEAL in its entirety. The relevant portions of this chapter are included in the proposed amendment to 467 NAC 5.

467 NAC 7 – *MHCP Providers*

The following regulations are proposed for AMENDMENT:

467 NAC 1 – *Administration*

The proposed changes include removing reference to other titles and chapters and updated with clarifying language; all definitions are now incorporated throughout the title; updated grievance and fair hearing rights; removing directions to agency staff; removing form names and numbers; restructure the regulatory chapter; and update formatting.

467 NAC 2 – *Referral, Application, and Eligibility for the Medically Handicapped Children's Program and the Genetically Handicapped Persons Program*

The proposed changes include removing examples of earned and unearned income; updating provisions on case actions and moving them to new subsections listed as notices. The propose changes will also remove directions for agency staff, lists of medical and service codes, forms, language for face-to-face interviews; and update formatting.

467 NAC 4 – *Diagnoses and Services for the Genetically Handicapped Persons Program*

The proposed changes will incorporate relevant portions formerly in 467 NAC 5, with amendments setting out requirements regarding service locations, out-of-state services,

and non-covered services formerly incorporated by reference to other regulations; removing eligibility and rights provisions proposed for inclusion in 467 NAC 1-2; streamlining and standardizing the subsections on specific diseases so that they contain the same elements included in 467 NAC 3; removing lists of service components; removing directions for agency staff; and update formatting.

467 NAC 5 – *Medical Providers and Payments for the Medically Handicapped Children's Program and Genetically Handicapped Persons Program*

The proposed changes will incorporate the relevant portions formerly in 467 NAC 7, with amendments that simplify reimbursement by using the Medicaid rate, rather than separate calculations; lengthen the billing period from 60 days to 6 months, as required by federal law; and require providers to retain records for 6 years, not 4 years. The proposed changes will also rely on Medicaid fee schedules for reimbursement rates; remove directions for agency staff; and update formatting.

467 NAC 6 – *Referral, Application, Eligibility, and Services for the Disabled Children's Program*

The proposed changes include increasing the monthly reimbursement rate for respite care providers so that it aligns with the Lifespan Respite program; removing Supplemental Security Income from the program name; authorizing the re-use of agency background checks with respite care providers; specifying that the certification date is always the date when the agency receives the application; and relying on the federal mileage reimbursement rate, rather than one prescribed in regulation. The proposed changes will also remove directions for agency staff, references to grievances and fair hearings, references to specific forms, language on face-to-face visits, and references to services no longer utilized due to other resources, as well as update formatting.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Due to the current public health crisis, the agency will enforce any Directed Health Measure Order on the size of gatherings that is in effect at the time of the hearing. In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments.

Interested persons may provide verbal comments by participating via phone conference line by calling 877-399-1398; Participant code: 3213662#.

Interested persons may provide written comments by mail, fax, or email, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of

the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8223. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 467	Prepared by: Staci Zuerlein
Chapter: 1,2,3,4,5,6	Date prepared: 02/24/21
Subject: Medically Handicapped Children's Program	Telephone: (402) 405-2509

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

The proposed regulations make two changes whose costs, when combined, are anticipated to offset each other. One change involves reimbursing medical providers using Medicaid rates, instead of Medicaid rates plus 10%. This change is anticipated to result in a savings of approximately $20,000 per year. The other change involves increasing the monthly reimbursement rate for respite care providers from $75 to $125. This change is anticipated to cost approximately $20,000 per year. The services are funded with both federal and state funds using a 4:3 ratio.

Political Subdivision: NA

Regulated Public: NA

If indeterminable, explain why: NA

TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 1 ADMINISTRATION

001. SCOPE AND AUTHORITY. The Medically Handicapped Children's Program includes Title V Services for Medically Handicapped Children's Program, Genetically Handicapped Persons Program, and Disabled Children's Program.

001.01 PURPOSE. The purpose of the Medically Handicapped Children's Program is to develop, improve, and strengthen standards and services for children with special health care needs and:

(A) To promote systems development to improve the organization and delivery of high quality services for children with special health care needs and their families with an emphasis on community-based services;
(B) To promote coordinated comprehensive care within a medical home;
(C) To provide culturally competent services and support by assisting families of children with special health care needs within a community and to identify and meet their needs through coordination of informal and formal supports;
(D) To develop, promote, and improve the standards of care for children with special health care needs;
(E) To promote efforts that emphasize early evaluation and treatment, health-related education and advocacy in order that children with special health care needs and their families may maximize their full potentials; and
(F) To increase public awareness through the establishment of outreach efforts.

001.02 LEGAL BASIS. Title V Services for the Medically Handicapped Children's Program is administered under Public Law 97-35, Subtitle D, 42 United States Code (U.S.C.) §§ 701-713, "Title V Maternal and Child Health Services Block Grant", and Nebraska Revised Statute (Neb. Rev. Stat.) §§ 43-522, 68-309, and 68-717. The Genetically Handicapped Persons Program is a program for adults with cystic fibrosis, hemophilia, and sickle cell disease established by Neb. Rev. Stat. §§ 68-1401 to 68-1406. The Disabled Children's Program is administered by the Department as part of the Title V Maternal and Child Health Services Block Grant.

001.03 FUNDING. The Medically Handicapped Children's Program and Disabled Children's Program are funded by a federal block grant and state funds appropriated by the legislature. The Genetically Handicapped Persons Program is funded by state funds appropriated by the legislature. The Department has the authority to set priorities of services and service components based on available funding. Donations may be accepted.

002. APPLICANT AND RECIPIENT RIGHTS. Applicants and recipients applying for or receiving services have the rights to confidentiality, non-discrimination, and grievance and fair hearing.

002.01 CONFIDENTIALITY. Applicants and recipients have the right to have their information treated confidentially.

002.02 NON-DISCRIMINATION. No individual may be subjected to discrimination on the grounds of his or her race, color, national origin, sex, age, disability, religion, or political belief.

002.03 GRIEVANCE AND FAIR HEARING. Applicants and recipients have the right to a Fair Hearing on any action or inaction with regard to an application, the amount of assistance, or failure to act with reasonable promptness. The appeal must be filed in writing within 90 days of the Department's action or inaction.

002.04 APPLICANT AND RECIPIENT RESPONSIBILITIES. Applicants, recipients, parents, and legal guardians must comply with the following:

(A) Report accurate financial information;
(B) Report accurate information about the applicant's or recipient's needs;
(C) Report a change of address, household size, or income within ten days following the change;
(D) Participate in any financial or medical eligibility review;
(E) Notify the Department before receiving services at scheduled appointments and tests;
(F) Keep all appointments for care and services related to the special health care need;
(G) Follow the individual medical treatment plan;
(H) Notify the Department of any emergency care or hospitalizations within five working days;
(I) Obligate payment for any part of treatment which has been determined to be the recipient's responsibility;
(J) Assume responsibility for the general health care of the recipient; and
(K) Ensure the Department and medical providers have any third party liability information prior to care, if applicable, and supply necessary documentation for filing claims before the Medically Handicapped Children's Program, Genetically Handicapped Persons Program, and Disabled Children's Program pays for any service.

TITLE 467
TITLE V SERVICES FOR MEDICALLY HANDICAPPED CHILDREN, GENETICALLY HANDICAPPED PERSONS' PROGRAM, AND SUPPLEMENTAL SECURITY INCOME-DISABLED CHILDREN'S PROGRAM

CHAPTER 1-000 ADMINISTRATION

1-001 Introduction: The Medically Handicapped Children's Program (MHCP) includes Title V Services for Medically Handicapped Children, the Genetically Handicapped Persons' Program, and the Supplemental Security Income-Disabled Children's Program. Remains in section 001 as modified

1-001.01 The purpose of the Medically Handicapped Children's Program is to develop, improve, and strengthen standards and services for children with special health care needs and –

1. To promote systems development to improve the organization and delivery of high quality services for children with special health care needs and their families with an emphasis on community-based services.
2. To promote coordinated comprehensive care within a medical home.
3. To provide culturally competent services and support by assisting families of children with special health care needs within a community and to identify and meet their needs through coordination of informal and formal support(s).
4. To develop, promote, and improve the standards of care for children with special health care needs.
5. To promote efforts that emphasize early evaluation and treatment, health-related education and advocacy in order that children with special health care needs and their families may maximize their full potentials.
6. To increase public awareness through the establishment of outreach efforts. Remains in section 001 as modified

1-001.02 Legal Basis: Title V Services for Medically Handicapped Children is administered under Public Law (P.L.) 97-35, Subtitle D, Section 501(a)(4), under "Title V Maternal and Child Health Services Block Grant", and Neb. Rev. Stat. Sections 43-522, 68-309, and 68-717.

The Genetically Handicapped Persons' Program is a program for adults with cystic fibrosis, hemophilia, and sickle cell disease established by Neb. Rev. Stat. Sections 68-1401 to 68-1406.

The Supplemental Security Income-Disabled Children's Program (SSI-DCP) administered in Nebraska by the Nebraska Department of Health and Human Services is part of the Maternal and Child Health block grant. Remains in section 001 as modified

1-001.03 Funding: MHCP is funded by a federal block grant and state monies appropriated by the Legislature. The Department may set priorities of services and service components based on available funding. Donations may be accepted. Remains in section 001 as modified

1-001.04 Confidentiality: See 465 NAC 2-005 ff. Remains in section 002 as modified

1-001.05 Non-Discrimination: See 465 NAC 2-001 ff. Remains in section 002 as modified

1-002 Definitions: The following definitions apply within this title.

Active Treatment means treatment which is directed immediately to the cure, maintenance or improvement of the client's medical condition.

Acute Condition means a medical condition having a sudden onset, sharp rise, and a short course.

Certification means a process in which the client is approved for a specific individual medical treatment plan and is determined financially eligible; authorization for specific care is then approved.

Chronic Condition means a medical condition that is slow in its progress and long in duration which can be improved or maintained through active medical treatment or stabilized.

Client means an individual who has been referred to, has applied for, or is certified for MHCP.

Clinic means a process in which MHCP-contracted or approved medical specialists, including the family evaluate the client and formulate the individual medical treatment plan (IMTP) in an MHCP-designated setting.

Consultative Services means any medical evaluation which is likely to assist in determining a diagnosis and the IMTP.

Deductions means those items that are directly subtracted from the family's countable income and resources before comparison to the MHCP financial guidelines to determine financial eligibility.

Diagnostic Services means any medical evaluation approved by MHCP to provide a diagnosis and the IMTP.

Emancipated Minor means when determining financial eligibility, a child age 18 or younger who is considered an adult because s/he has-

1. Married; or
2. Moved away from the parent(s)' home and is not receiving support from the parent(s).

Family means a unit consisting of one or more adults (individuals age 19 or older) and one or more children related by blood, marriage, or adoption who are considered members of the household unit. An unborn child may be included if proof of pregnancy is obtained. The following are considered separate families:

1. Related adults other than spouses and unrelated adults who reside together;
2. Children living with non-legally responsible relatives; and
3. Emancipated minors.

Financial Margin means twenty-five percent of the amount by which the family's countable income and resources exceed the MHCP financial guidelines minus the disregard and financial margin deductions. See 467 NAC 2-004.06.

Financial Margin Deductions means those items that are subtracted from the financial margin to determine any amount that the client, parents, or guardian must obligate on the client's medical care. See 467 NAC 2-004.06A.

Individual Medical Treatment Plan (IMTP) means a written individualized plan developed by an MHCP-contracted physician specialist or a clinic team which prescribes specific treatment and/or diagnostic evaluation.

Maximum Benefit means the point at which the client has received all the medical services that MHCP is able to provide for that client's condition; also when no active treatment plan is recommended.

Medically Handicapped (Children with Special Health Care Needs) means children under twenty-one years of age who experience an orthopedic condition, cerebral palsy, cystic fibrosis, heart disease, an eye problem amenable to surgery, an oral plastic handicap, mid-line birth defect, hearing problem, neoplasm, or any other major illness which is disabling or will lead to a disability and for which an active treatment plan is indicated. Care for acute conditions, such as infectious disease, appendectomy, or simple fractures, is not covered under this program.

Multi-Disciplinary Team means a team of specialized personnel contracted by MHCP to assess clients with specific conditions and to provide IMTP's at MHCP-sponsored clinics.

Prudent Person Principle means the practice of assessing all circumstances regarding case eligibility and using good judgment in requiring further verification or information before determining initial or continuing eligibility.

Referral means an action by which a family or individual desires to receive services for children with special health care needs is made known to an office of the Department of Health and Human Services.

Specialized Physician means an individual with a degree of Medical Doctor, or its equivalent, from an accredited medical school, who has been recognized and certified by a specific academy (suborganization) of the American Medical Association by having completed the mandatory course of study and having passed an examination which entitles membership as a recognized specialist in a specific body of knowledge.

1-003 Cooperative Responsibilities: The system by which Medically Handicapped Children's services are provided is a cooperative undertaking by volunteers, Department staff, and the client, parent(s), or guardian.

1-003.01 Responsibilities of the Client, Parents, or Guardian: The client, parent(s), or guardian must – Remains in section 002 as modified

1. Notify the MHCP services coordinator before receiving services at scheduled appointments and laboratory tests;
2. Keep all appointments for care and services;
3. Follow the individual medical treatment plan;
4. Notify the MHCP services coordinator of emergency care and hospitalizations within five working days;
5. Obligate payment for that part of the treatment which has been agreed upon by MHCP and the client or has been determined to be the client's responsibility;
6. Assume responsibility for general health care for the client;
7. Ensure that the appropriate provider receives payment from health insurance funds, if available, before MHCP pays for any service by supplying necessary information and forms to the provider or by filing claims with an insurance company if necessary;
8. Report accurate financial and social information;
9. Report a change of address, household size, or income within ten days following the change; and
10. Participate in any MHCP financial and/or medical eligibility review.

Note: The responsibilities of the child's parent or guardian for the SSI-DCP are listed in 467 NAC 6-001.04.

1-003.02 Responsibilities of Services Coordinator: The services coordinator must –

1. Accept referrals for MHCP and DCP services;
2. Assist the parent(s) or guardian in the application process;
3. Conduct needs assessments with the family;
4. Determine financial eligibility for the MHCP Title V and Genetically Handicapped Persons' Program (see 467 NAC 2-004 ff.);
5. Verify financial and pertinent information using the prudent person principle;
6. Verify medical eligibility for the MHCP Title V and Genetically Handicapped Persons' Program (see 467 NAC 2-003 ff.);
7. Submit cases requiring medical review for approval of medical care to the Central Office;
8. Notify clients, families/individual, appropriate staff, providers, and clinic personnel of children assigned to a particular clinic;
9. Attend MHCP clinics as assigned and function as the social services coordinator member of the clinic team, and as the Department's representative. Dictate narrative of the interview with the family at the clinic as part of the clinic report;
10. Function as the lead services coordinator at MHCP-sponsored clinics, when assigned;
11. Collaborate with the nurse clinic coordinator on scheduling children into the clinic, regarding lab work, x-rays, or any other pre-clinic evaluations necessary, as well as determining what information/reports are needed from other sources to assist in the clinic evaluation process;
12. Collaborate with the nurse clinic coordinator to make sure that recommendations from the previous clinic have been completed, are in progress, or may need further consult with the clinic team before proceeding further;
13. Determine which families need to attend clinic based on priorities dictated by each individual team;
14. Work with families to schedule appointments and provide notification;
15. Assure that medical records are sent to the appropriate clinic staff as required by each individual clinic;
16. Assure that all clinic lists are printed and distributed as required by the lead services coordinator for the clinic;
17. Meet with the family at clinics to discuss the reason for the referral, clinic expectations, program guidelines, family's priorities and concerns, treatment plan, payment sources, and possible resources to meet the needs of the family which may be in addition to the medical needs;
18. Advocate for the family regarding any questions or concerns about the treatment plan;
19. Assist the nurse coordinator in helping the family to understand the team's recommendations and who will assist in follow-up;
20. Collaborate with the nurse consultant to arrange tests for follow-up appointments, or any test results that may need follow-up prior to the next clinic;
21. Work with the family and nurse coordinator to see that the family has the assistance they need to follow through on the recommendations or Individual Treatment Plan;
22. Coordination of Care: Assist the client, parents, or guardian in arranging follow-up care as recommended by the team, encouraging the client, parents, or guardian to make the appointments.

23. Send appropriate authorizations for care, treatment, tests, or equipment;
24. Distribute clinic reports to family and family physicians, schools and other providers as dictated by the family and as is appropriate;
25. Certify cases as medically and financially eligible for MHCP Title V, Genetically Handicapped Persons Program, as assigned;
26. Authorize medical care according to the medical care guidelines in accordance with the individual medical treatment plans as directed by the medical consultant;
27. Conduct personal interviews to assess needs and help families to identify their strengths and areas where assistance may be necessary;
28. Initiate and/or maintain case files and narratives;
29. Perform services coordination and make referrals as needed or requested by the family;
30. Convene teams of community personnel, medical personnel, local agency representatives, school personnel, etc., when necessary to meet the needs of the family in getting all the services they may need;
31. Provide technical assistance about children with special health care needs, consultation and/or coordination to HHS coworkers and community agencies;
32. Work with local community as the contact/expert regarding children with special health care needs to encourage referrals to MHCP/DCP and serve as a resource to the local community; and
33. Coordinate with appropriate programs at the request of the family.

1-004 Grievances and Fair Hearings: The grievance procedure is at the client's option. The individual may contest the decision and request a hearing without following the grievance procedure (see 467 NAC 1-004.04). Remains in section 002 as modified

1-004.01 Grievance Request: The client or the client's representative who is dissatisfied with any action or inaction with regard to the furnishing or denial of services may file a formal grievance request for administrative review and redetermination within 90 days of that action. This review is made by a member(s) of the administrative staff of the Medically Handicapped Children's Program. The request for review and redetermination must –

1. Be made in writing;
2. State the identifying information, including name and address of the client in whose behalf the review is requested;
3. State the specific cause for the request of the review;
4. Be signed and dated by the person requesting the review; and
5. Be directed to the Administrator, Attention: Medically Handicapped Children's Program Administrative Review Team.

A member of the review team must contact the person who signed the grievance within five working days of receipt of the request. The purpose of this contact is to determine that all existing information regarding the action resulting in the grievance was available to and considered by the Department at the time the decision which resulted in the dissatisfaction was made. The parties submitting the grievance must cooperate to the best of their ability to provide any additional information that may exist.

1-004.02 Review: The review consists of a complete re-examination of all documents and other available information on the case and, if requested by the aggrieved party may include a meeting for an informal discussion of the matter between the aggrieved party, his/her representative (if any), and MHCP administrative staff conducting the review.

1-004.03 Statement of Determination: A written statement of the redetermination and resulting appropriate action by the Medically Handicapped Children's Program must be sent to the person requesting the review within five days after the receipt of appropriate additional information and meeting, if any. An individual who is not satisfied with the decision has the right to request a fair hearing on the decision. If the child is found eligible, MHCP will authorize payment for covered services provided during the grievance procedure.

1-004.04 Request for Administrative Hearing: A client or the client's representative may contest any action or inaction with regard to MHCP, including a decision resulting from a grievance within 90 days of the date of the action or inaction. The request for fair hearing must follow 465 NAC 2-001.02 and 6-000.

1-005 (Reserved):

1-006 Summary of Forms: The following forms are used for Title V Services for Medically Handicapped Children, the Genetically Handicapped Person's Program, and the SSI Disabled Children's Program. Instructions for these forms are contained in the appendix.

Form #	Form Title	Appendix Reference
MHC-10	Client Information	467-000-20
MHC-11	Medical Eligibility Determination Inquiry and/or Clarification of Coverage	467-000-21
MHC-13	Medically Handicapped Children's Program Phone Referral	467-000-23
MHC-14	Appointment Notice	471-000-24
MHC-16	Exchange of Information	467-000-26
MHC-24	SSI-Disabled Children's Program Billing Document	471-000-34
MHC-34	Eligibility Computation	467-000-44
MHC-44	MHCP Service and Device Application	467-000-13
MHC-49	Appointment Postcard	467-000-59
MHC-110	Referral Form	467-000-120

1-007 Title Organization: This title is organized as follows:

1. Chapter 1-000, "Administration;"
2. Chapter 2-000, "Referral, Application, and Eligibility,"
3. Chapter 3-000 (Reserved);
4. Chapter 4-000, "Title V Services for Medically Handicapped Children;"
5. Chapter 5-000, "The Genetically Handicapped Persons' Program;"
6. Chapter 6-000, "The Supplemental Security Income Disabled Children's Program (SSI-DCP);" and
7. Chapter 7-000, "MHCP Providers."

TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 2 REFERRAL, APPLICATION, AND ELIGIBILITY FOR THE MEDICALLY HANDICAPPED CHILDREN'S PROGRAM AND THE GENETICALLY HANDICAPPED PERSONS PROGRAM.

001. REFERRAL. Any individual, health care professional, or agency may refer a potential applicant to the Medically Handicapped Children's Program or Genetically Handicapped Persons Program.

001.01 INITIATING A REFERRAL. A referral for services is made by the applicant, any individual, health care professional, or agency. A referral is made by completion of the application or, at a minimum, providing the Department with the potential applicant's following information:

(1) Name;
(2) Date of birth;
(3) Parent or legal guardian's name;
(4) Address;
(5) Phone number;
(6) Diagnosis or medical condition; and
(7) Reason for referral.

001.01(A) EMERGENCY REFERRAL. A hospital emergency department who wishes to refer potential applicants must make the referral within five days of admission to the hospital.

002. APPLICATIONS. Upon receiving a referral, the Department will mail the potential applicant an application form and a release of information form. The Department must receive the completed application and signed release from the applicant within 30 days after the Department mails the forms. A legally responsible adult age 19 or older must complete the application.

002.01 RESIDENT OF NEBRASKA. Applicants and recipients must reside in Nebraska.

002.02 CITIZENSHIP. The applicant must be a citizen of the United States of America or a qualified alien and be lawfully present in the United States of America as required by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 4-108 to 4-112. The applicant must sign an attestation required by Nebraska Revised Statute (Neb. Rev. Stat.) § 4-111. The applicant's citizenship or alien status must be verifiable by the Department.

002.03 AGE REQUIREMENT. The age requirement for the Medically Handicapped Children's Program is birth through 20 years. The age requirement for the Genetically Handicapped Persons Program is 21 years and older.

002.04 WITHDRAWAL. The applicant may voluntarily withdraw an application.

003. MEDICAL AND FINANCIAL ELIGIBILITY. Eligibility for the Medically Handicapped Children's Program and Genetically Handicapped Persons Program is based on medical eligibility and financial qualifications. Current medical and financial information must be provided.

003.01 MEDICAL ELIGIBILITY DETERMINATION. Medical eligibility is determined by either the Department or Department designated medical reviewer. If an applicant is seen by a Department designated clinic team, medical eligibility can be determined without going through the medical reviewer. Eligibility is specific to one or more diagnosis and each diagnosis must meet the qualifications in Chapter 3. To determine eligibility, the medical records must include the diagnosis and a current individual medical treatment plan developed by a physician, physician assistant, or nurse practitioner. Medical records submitted must have a date of service less than six months prior to the determination request date.

003.02 MEDICAL ELIGIBILITY REVIEWS. Current medical specialty reports must be received for the eligible diagnosis at the time of review annually. Department designated clinic team reports may take the place of a specialty report. Medical eligibility for reviews are not determined by a medical consultant.

003.03 FINANCIAL ELIGIBILITY DETERMINATION. Financial eligibility is determined based on the probable cost of specialized medical care and the income and resources available to the applicant, parents, or legal guardians. The recipient's income must be at or below 185 percent of the federal poverty level for the appropriate family size after countable income is figured minus deductions. If the family's income minus deductions exceeds the requirement, a financial margin must be calculated. Countable income includes all income not listed as exclusions in the Title.

003.03(A) INCOME EXCLUSIONS. The following are excluded as sources of income:

(i) Withdrawals of bank deposits;
(ii) Money borrowed;
(iii) Tax refunds;
(iv) Cash gifts under $500;
(v) Earnings of all children age 18 years and younger;
(vi) Child or spousal support;
(vii) Subsidized adoption or subsidized guardianship payments from Title IV-E or child welfare funds;
(viii) Value of United States Department of Agriculture donated foods;
(ix) Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
(x) Loans, grants, and scholarships obtained and used under conditions that prohibit the use for current living costs;
(xi) Alaska Native Claims Settlement Act payments to the extent the payments are exempt from taxation under section 21(a) of the Act;

(xii) Value of Supplemental Nutrition Assistance Program and the special food service program for children under the National School Lunch Program Child Nutrition Act of 1966, as amended;
(xiii) Money awarded by the Indian Claims Commission or the Court of Claims;
(xiv) Reimbursement of expenses or payments for services from the Senior Companion Program, AmeriCorps, Senior Corps, Foster Grandparents, Service Corps of Retired Executives, Experience Works, and any other programs under Title II and III of Public Law 93-113;
(xv) Payments to an individual participating in training or school attendance subsidized Vocational Rehabilitation within the Nebraska Department of Education; and
(xvi) Low Income Energy Assistance funds;

003.03(B) FINANCIAL DEDUCTIONS. The following are deducted from the countable income:
(1) Child support paid;
(2) Spousal support or alimony paid;
(3) Child care necessary for employment or education if both parents are employed or receiving education or if one parent is unavailable to care for the child due to absence or incapacity. This excludes students pursuing second undergraduate degrees and certificates or any post-graduate schooling;
(4) Tuition and books for family members attending school. This excludes students pursuing second undergraduate degrees and certificates or any post-graduate schooling; and
(5) Medical expenses for the entire family, including medical insurance premiums, paid within the 12 months preceding the date of application.

003.03(B)(i) MEDICAL EXPENSE DEDUCTION REDETERMINATION. Medical expenses allowed for the previous year's financial margin are not counted for the current year's medical expenses. The medical expenses deducted and allowed on the previous year's application must be deducted at the time of redetermination.

003.03(C) RESOURCE LIMITS. There are no resource limits for these programs.

003.03(D) FINANCIAL MARGIN. The financial margin is the recipient's responsibility that must be paid annually, after any third party, on the recipient's specialized health care prior to the Department making any payments. If the family's income minus deductions exceeds the income requirement, a financial margin must be calculated. The financial margin is 25 percent of the amount which exceeds the income requirements minus the financial margin deductions.

003.03(D)(i) FINANCIAL MARGIN DEDUCTIONS. The following are deducted from the financial margin:
(1) Unpaid medical bills for the applicant or recipient, not included in previous year's medical allowance;
(2) Projected travel and lodging costs using state employee rates for specialized medical care; and
(3) Projected costs of child care for siblings while the client is hospitalized or receiving medical services.

003.04 FINANCIAL ELIGIBILITY REVIEWS. Financial eligibility redetermination must be completed annually or at the time of any changes in income or family size.

003.05 MEDICAID ELIGIBLE WITH SHARE OF COST. Applicants and recipients must apply for Medicaid if a referral is appropriate. If the applicant or recipient is eligible or denied Medicaid with a high share of cost, the Department may request Medicaid be open with the share of cost based on the cost savings for the program and benefit to the applicant or recipient. Funds may be used towards medical care not to exceed the Medicaid share of cost. The applicant or recipient is considered Medicaid eligible once the share of cost is met.

004. NOTICES FROM DEPARTMENT. A notice is sent to applicants and recipients in the following instances:

(A) An applicant is determined eligible or ineligible for the program;
(B) A recipient is determined eligible or ineligible at time of redetermination; or
(C) Services are reduced or terminated.

005. NOTICES NOT REQUIRED BY DEPARTMENT. A notice is not sent to applicants or recipients in the following instances:

(A) Services are no longer needed and applicant or recipient requests the closure;
(B) Applicant or recipient has died;
(C) Applicant or recipient becomes institutionalized;
(D) Applicant or recipient whereabouts are unknown; or
(E) Failure to act upon request for redetermination.

CHAPTER 2-000 REFERRAL, APPLICATION, AND ELIGIBILITY

2-001 Initial Referral: Individuals, parents, guardians, agencies, and physicians may refer an individual to MHCP. An application may be completed before or after the referral is received (see 467 NAC 2-002). An application may serve as a referral. Remains in section 001 as modified

2-001.01 Referral to MHCP: Any individual may be referred to MHCP Title V, SSI/DCP and/or Genetically Handicapped Person's Program for diagnostic, consultation services, and/or needs assessment (see 467 NAC 6-003) without -

1. Charge to the individual or the individual's family, except for payment by a third party which is authorized or under legal obligation to pay the charges; and
2. Any restriction on or requirement regarding the economic status of the individual's family or relatives.

2-001.02 Types of Referrals: A referral for services may be made by -

1. Completion of the MHCP application by the applicant, the parent(s) or legal guardian, an individual acting under a duly executed power of attorney, or another person authorized to act for the applicant. Note: The application must list the client's diagnosis or medical problem, and at a minimum must include name of client, date of birth, phone, parents, address, and reason for referral; Remains in section 001.01 as modified
2. A physician's referral completed by a physician provided to any office of the Department of Health and Human Services; or
3. Any interested person by phone, personal interview, or letter to any office of HHSS. Any written material received is considered the referral.

2-001.02A Physician's Referral: A physician may request both a diagnostic evaluation and/or treatment.

2-001.02B Referral by Interested Individual or Agency: Any parent or guardian or any other individual or agency with the consent of the parent or guardian may request an MHCP evaluation. Exception: MHCP provides diagnostic evaluations for eye or hearing services only when the referral is made by a medical professional or para-professional.

2-001.02C Emergency Referral: Physicians may refer clients to MHCP by telephone in case of emergency. MHCP Central Office staff may conditionally approve admission to an MHCP-contracted hospital pending medical and financial eligibility. Remains in section 001.01(A) as modified

2-001.03 Receipt of Referrals

2-001.03A Referrals Received by the MHCP Offices: MHCP staff assign the case to a services coordinator. The services coordinator must send a letter acknowledging the referral, and initiate entries into computer.

2-001.04 Case Assignment: Families are served through the various HHS offices based on –

1. The client's geographical location;
2. The medical diagnosis;
3. The location of the nearest and most timely clinic that will meet the client's immediate needs; and
4. Client's family's or caregiver's choice when appropriate.

2-001.04A Children with Multiple Service Needs: For a child/client with multiple diagnoses (and multiple MHCP services), Central Office staff will assign a specific services coordinator or office to work with the family to avoid multiple services coordinators.

2-001.04B Referral Acknowledgment: Within ten working days after the services coordinator receives the case information, the services coordinator must notify the referral source when appropriate, and the parent or client of the receipt of the referral and the decision/action initiated by the referral. This may include-

1. A determination of medical eligibility;
2. The date of a clinic appointment or appointments with other specialists;
3. A request for additional information;
4. A request for Central Office review;
5. A request for medical information;
6. A request for completion of application; or
7. Referral to other programs.

The services coordinator must request the completion of release of information forms. The services coordinator must also initiate the narrative portion of the case file at this time.

2-001.04B1 Completion of Release of Information: When requesting completion of release of information forms, the services coordinator must allow 30 days for response. If no response is received in the first 15 days, the services coordinator must make personal contact with the client/family. If a response is not received within the 30-day period, the services coordinator must make every attempt to contact families and/or referral source before rejecting. Remains in section 002 as modified

2-001.04C Social Security Number: A social security number is not required as a condition of eligibility.

In order to facilitate the application process and to coordinate benefits for other programs, the services coordinator will request the applicant's SSN. The applicant may choose to provide a SSN.

For those persons for whom a SSN is not provided, a client identification number may be obtained from the Central Office.

The services coordinator must update this information on the computer system.

2-002 Applications: To apply for MHCP, the person who is legally responsible for the client must complete the application (attached see 467-000-13). An individual age 19 or older who is legally responsible must complete the application on his/her own behalf. Application may be made either before or after medical eligibility is determined. Remains in section 002 as modified

To be certified eligible for MHCP the applicant shall be a citizen of the United States of American or a qualified alien under the federal Immigration and Nationality Act and be lawfully present in the United States, as required by Neb. Rev. Stat. § 4-108 to 4-112. Citizenship section remains in section 002.02 as modified

1. Attestation: The applicant shall attest that s/he is a citizen of the United States of America or that s/he is a qualified alien under the federal Immigration and Nationality Act, 8 USC 1101 et seq., as such act existed on January 1, 2009; and is lawfully present in the United States. The applicant shall provide his/her immigration status and alien number, and agree to provide a copy of his/her United States Citizenship and Immigration Services (USCIS) documentation upon request;
2. Verification: For any applicant who has attested that s/he is a qualified alien under 467 NAC 2-002, item 1, eligibility for benefits shall be verified through the Systematic Alien Verification for Entitlements Program. Until verification of eligibility is made, the attestation may be presumed to be proof of lawful presence unless the verification is required before providing the public benefit under another provision of state or federal law.

An application may be made for an unborn child, but no case action will be taken until the child is born. If the family should request services prior to birth, medical reports specifying the need must be submitted to the Central Office for determination of coverage.

2-002.01 Application Process: The services coordinator must conduct a face-to-face interview with the family including the client within six months after the case action date and as often as needed for services coordination but at a minimum of once each year after the first year of eligibility.

2-002.01A Time Guide for Application: MHCP allows the applicant 30 days from the date of the letter notifying the client of medical eligibility to make a financial application. If the client does not respond within 15 days from the date of the letter, the services coordinator must make personal contact with the client, parent(s), and/or guardian to complete the application process within a total of 45 days. If appropriate, the services coordinator may notify the referral source that the family did not apply.

Current medical and financial information must be obtained. MHCP considers any medical information less than six months old to be current. Remains in section 003 as modified

2-002.01B Withdrawal: The applicant may voluntarily withdraw an application.
Remains in section 002.04 as modified

2-003 Medical Eligibility: Eligibility for MHCP is based on two components: medical eligibility and financial eligibility. To verify medical eligibility, the services coordinator must receive the diagnosis and the individual medical treatment plan (IMTP - also see definition at 467 NAC 1-002). The IMTP is developed by a physician or a clinic team. Based on the physician's diagnosis and the IMTP, the services coordinator must verify medical eligibility by using the chart at 467 NAC 2-003.02. Certain cases must be reviewed by the medical consultant (see 467 NAC 2-003.01B). Remains in section 003 as modified

The medical consultant must determine medical eligibility within five working days after all necessary information is received by the medical consultant.

2-003.01 Codes: The chart at 467 NAC 2-003.02 contains the following types of codes:

1. International Classification of Diseases ICD-9-CM codes (diagnosis codes);
2. Medical eligibility status codes; and
3. Service codes.

The services coordinator must enter the diagnosis and service codes into the computerized system.

2-003.01A ICD Codes: These are numerical codes for the client's diagnosis.

The services coordinator must use the International Classification of Diseases to obtain the diagnosis code based on the physician's diagnosis.

2-003.01B Medical Eligibility Status Codes: These codes indicate the client's medical eligibility status. The medical eligibility status codes are -

1. E: Medically eligible;
2. NE: Not medically eligible; and
3. R: To be reviewed by the medical consultant.

2-003.01C Service Codes: The service codes indicate the MHCP service for which each code is eligible. This information may be used to determine which services coordinator is responsible for each case; it also identifies the funding for program purposes. The code "00" indicates that the medical consultant will determine the appropriate service for each case. The service codes are -

00 To be assigned when medical eligibility is determined
02 Rheumatoid Arthritis
03 Scoliosis
04 Hemophilia
05 SSI/DCP
06 Genetically Handicapped Person's Program
07, 08, Reserved
09 Services Coordination only
10 Screening (for assignment or diagnostic purposes only - see 467 NAC 2-001.04)
11 Craniofacial conditions
12 Cerebral Palsy
13 Heart
14 Orthopedic, General
15 Cystic Fibrosis
16 Eye
17 Mid-line Neurological Defects

18 Hearing Loss
19 Diabetes
20 Neoplasm
21 Major Medical, General
22 Reserved
23 Premature/High Risk Infants
24 Asthma
25 Burns
26 Neurological
27 Urological
28 Reserved
29 Services Coordination

2-003.02 Medical Eligibility Chart: The services coordinator must use the following chart to verify medical eligibility.

ICD Codes	Medical Eligibility Status	Service Code
000 - 010.9	NE	
011 - 013.9	R	00
014 - 014.8	NE	
015 - 015.9	E	14
016 - 018.9	R	00
020 - 041.9	NE	
045 - 045.1	E	14
045.2 - 045.9	NE	
046 - 047.9	NE	
048 - 049.9	R	00
050 - 061	NE	
062 - 064	R	00
065 - 092.9	NE	
093 - 094.9	R	00
095 - 129	NE	

ICD Codes	Medical Eligibility Status	Service Code
130 - 130.9	R	00
131 - 136.9	NE	
137 - 137.4	R	14
138	E	14
139.0	R	14
139.1	R	
139.8	R	
140 - 209	E	20
210 - 239	R	20
240	NE	
241	R	21
242 - 244	E	21
245 - 246	R	21
250	E	19
251	R	00
252 - 253	E	21
254 - 259	R	21
260 - 268	R	00
268.0 - 268.1	E	14
268.2 - 269	R	00
270 - 273	R	21
274	R	00
275 - 276	R	21
277.0	R	15 (Adults-06)
277.1 - 277.9	R	21
278	NE	
279	R	21
280 - 281	NE	
282 - 283	R	21 (Adults - 06)
284	E	21
285	R	21
286.0 - 286.1	E	04 (Adults - 06)
286.2 - 286.9	R	21
287	R	21
288 – 289.9	R	21
290 – 307.22	NE	
307.23	R	21
307.3 – 326	NE	00
330 - 331.1	R	00
331.2	R	
331.3 - 331.4	R	00
331.7 - 331.9	NE	

ICD Codes	Medical Eligibility Status	Service Code
332.0	R	00
332.1	NE	
333 - 333.0	R	00
333.1	NE	
333.2 - 333.3	R	00
333.4	E	21
333.5 - 333.99	R	00
334 - 336.0	R	00
336.1 - 337.9	R	00
340 - 342	E	26
343 - 344	E	12
345	E	26
346	NE	
347 - 349.9	R	00
350 - 359.9	R	00
360.0 - 362.43	R	16
362.5 - 362.6	NE	
362.7	R	00
362.8 - 363.2	R	16
363.3 - 363.4	NE	
363.5 - 363.9	R	16
364.0	NE	
364.1 - 365.9	R	16
366.0	E	16
366.1	NE	
366.2 - 366.9	R	16
367	NE	
368.0 – 368.3	R	16
368.1 – 371.9	NE	
371 – 371.9	R	
372.0 - 372.39	NE	
372.4	R	00
372.5 - 377.2	NE	
377.3 - 377.6	R	00
377.7 - 377.9	NE	
378.0 - 378.7	E	16
378.8 - 378.9	R	00
379.0 - 379.2	NE	
379.3 - 379.4	R	00
379.5	R	16
379.8 - 379.9	R	00
380 - 382.0	NE	
382.1 - 382.9	R	18
383.0	NE	
383.1 - 385.9	R	18
386	NE	

ICD-9 Codes	Medical Eligibility Status	Service Code
387	R	18
388.0 - 388.1	NE	
388.2	R	18
388.3	NE	
388.4 - 388.5	R	18
388.6 - 388.9	NE	
389	R	18
390 - 397	E	13
398	R	13
401 - 405.9	R	00
410 - 417.9	E	13
420	NE	
421 - 427.69	R	13
427.8 - 427.89	R	13 and/or 29
427.9 - 429	R	13
430 - 438	R	00
440 - 442	E	13
443 - 448	R	00
451	NE	
452 - 453	R	00
454 - 455	NE	
456 - 459	R	00
460 - 466	NE	
470 - 471.9	R	00
472 - 492	NE	
493 - 494	R	24
495 - 511	R	00
512 - 513	R	00
514 - 518	NE	
519	R	
*520 - 525	E	
526 - 530.84	R	
531 - 551	NE	
551.2	R	21
551.3	R	21
551.4 - 553.2	R	21
553.3	R	21
553.8 - 553.9	R	21
555 - 555.9	R	19
556	R	19 or 21
557 - 558.2	NE	
558.9	R	19
560 - 570	NE	
571	E	21
572 - 573	R	00
574 - 576	NE	

*Only clients certified for service codes 11 and 12 are eligible for dental treatment under these codes.

ICD-9 Codes	Medical Eligibility Status	Service Code
577	R	00
578 - 579.1	NE	
579.2	R	19
579.3 - 579.9	R	00
580	NE	
581 - 582	R	27
583 - 584	R	27
585 - 590	R	
591 - 592	E	27
593	R	27
594	E	27
595	NE	
596	R	27
597	NE	
598	E	27
599	R	27
600 - 618	NE	
619	R	
620 - 709	NE	
710 - 711	R	14
712	R	02
713.0 - 713.1	R	
**713.2 (282.4-282.7)	R	21
(286.0-286.2)	R	04 (Adults 06)
(204.0-208.9, 202.3)	R	20
(203.0)	R	21
713.3 - 713.4	R	
***713.5	R	00
(094.0, 250.6, & 336.0)	R	00
713.6 - 713.7	R	
714.0 - 714.4	E	02
714.8 - 714.9	R	02
715	E	14
716.0 - 716.2	R	14
716.3 - 716.4	NE	
716.5 - 717.6	R	14
717.7	NE	
717.8 - 718.1	R	14
718.2 - 718.8	R	14
718.9	R	14
719.0 - 719.1	NE	
719.2 - 719.3	R	14
719.4	NE	

**Do not assign 713.2. Use the codes listed in parentheses as appropriate.

***This is a general condition. Use the codes listed in parentheses if appropriate.

ICD-9 Codes	Medical Eligibility Status	Service Code
719.5	R	14
719.6	NE	
719.7 - 719.9	R	00
720.0	E	02
720.1 - 721.5	R	14
721.6	R	00
721.7 - 726.0	R	00
726.1 - 726.11	R	14
726.12 - 727.09	R	14
727.1	R	14
727.2 - 727.3	R	14
727.4	R	
727.5 - 727.6	R	14
727.8	R	14
727.9	R	14
728.0	R	
728.10 - 728.11	R	14
728.12 - 728.19	R	14
728.2	R	
728.3	E	14
728.4 - 728.5	NE	
728.6 - 728.7	E	14
728.8 - 729.6	R	14
729.8 - 729.9	NE	
730 - 733	E	14
734 - 735	R	14
736 - 736.9	R	14
737 - 737.9	R	33
738 - 739.9	R	14
740	R	26
741 - 741.9	E	17
742	R	26
742.1 - 742.2	R	17
742.3	E	17
742.4 - 742.9	R	17
743.0 - 743.3	R	16
743.4 - 743.9	R	16
744.0 - 744.1	R	18
744.2	R	11
744.3 - 744.4	R	00
744.5	R	14
744.8 - 744.9	R	11
745.0 - 747.49	E	13
747.5 - 747.6	NE	
747.8 - 747.9	R	13
748.0 - 748.1	E	11

ICD-9 Codes	Medical Eligibility Status	Service Code
748.2	E	21
748.3 - 748.9	R	21
749.0 -749.25	E	11
750.0 - 750.2	R	11
750.3	E	21
750.4	R	21
750.5	R	21
750.6 - 750.9	R	21
751.0	R	00, 21
751.1	R	21
751.2 - 751.3	E	21
751.4 - 751.9	R	21
752.0 - 752.4	R	
752.5 - 753.1	R	27
753.2	E	27
753.3 - 753.4	R	27
753.5	E	27
753.6 - 753.9	R	27
754 - 755.1	R	00
755.2 - 755.60	R	14
755.61 - 755.69	R	14
755.8 - 755.9	R	14
756.0 - 756.10	R	00
756.11 - 756.19	R	00
756.2 - 756.3	R	14
756.4	R	14
756.50 - 756.51	E	14
756.52 - 756.59	R	14
756.6 - 756.7	E	21
756.8 - 757	R	14
757.0	E	14
757.1	R	14
757.2	NE	
757.3	R	21
757.4 - 757.9	R	
758.0 - 758.3	R	21
758.4	NE	
758.5 - 758.9	R	21
759.0 - 759.1	NE	
759.2 - 759.3	R	21
759.4 - 759.5	E	21
759.6 - 759.9	R	00
760 - 764.9	NE	
765.0 - 766.2	R	23
767.0	R	21, 23
767.1 - 767.3	R	

ICD-9 Codes	Medical Eligibility Status	Service Code
767.4	R	00
767.5	R	
767.6 - 767.9	R	00
768.0 -768.9	NE	
769	R	23
770.0 - 770.1	NE	
770.2 - 770.3	R	21, 23
770.4	R	00
770.5	R	21, 23
770.6	NE	
770.7	R	23
770.8 - 770.9	R	23
771	R	
772.0	NE	
772.1 - 772.2	R	21, 23
772.3 - 773.3	NE	
773.4	R	21, 23
773.5 - 774.6	NE	
774.7	R	21, 23
775 - 777.4	NE	
777.5 - 777.6	R	21, 23
777.8 - 777.9	NE	
778.0	R	21, 23
778.1 - 778.9	NE	
779.0	R	00
779.1 - 779.9	NE	

2-003.02A Medical Eligibility Response Codes: When the medical consultant reviews cases for medical eligibility, s/he must assign one of the following codes to each case to indicate the medical eligibility decision:

1. R_2: Medically eligible;
2. R_3: Not medically eligible (The client would be medically eligible if the problem were more severe);
3. R_4: No service available to cover this problem;
4. R_5: Not eligible, no active medical treatment plan (The client would be medically eligible if an active medical treatment was indicated or recommended);
5. R_6: Continued referral (Sufficient medical information is not available to make a decision on medical eligibility. The services coordinator must request new medical information as it becomes available); and.
6. R_7: Services Coordination only.

2-003.02B Continued Referrals: In evaluating the medical needs of a client referred to MHCP, the medical consultant may request more definitive diagnostic studies or a repeat evaluation at a later date before making a decision on medical eligibility. The medical consultant must code these cases as "R6". These requests are continued referral. Services coordination can be provided until determined medically eligible. MHCP does not cover recommended care during this period except for specific diagnostic studies which are authorized for payment by the medical consultant. The services coordinator must notify the client or the client's family of the continued referral by letter.

The services coordinator must assist families with their questions and concerns regarding the child's/family's needs, by referring to appropriate programs and services, until determined medically eligible.

2-003.03 Medical Eligibility Redetermination: For all services which do not conduct clinics, the services coordinator must submit the medical file, including a current progress report (i.e., a report completed within the previous six months) to the medical consultant for review. The services coordinator must attach a note to the case when submitting a case for review only. At the time of the financial review the services coordinator must determine the schedule for these medical reviews as follows: Remains in section 003.02 as modified

1. Compare the date of the financial review to the date of the most recent review by the medical consultant; and
2. If 12 months or more have passed, a review is due; or
3. If 11 months or fewer have passed, no review is due.

Note: Medical reviews by clinic teams may take the place of medical consultant reviews for those services.

2-004 Financial Eligibility: Financial eligibility for MHCP Title V services and for the Genetically Handicapped Person's Program is based on -

1. The probable cost of specialized medical care; and
2. Income and resources available to the parents or client to pay for the specialized medical care. Remains in section 003.02 as modified

2-004.01 Eligibility for Other Programs: An individual who is eligible for Social Services Block Grant, TANF, AABD, Food Stamps, any Medicaid (Title XIX or XXI of the Social Security Act) without a spenddown (see 467 NAC 2-004.01B), State Disability Program, Low Income Energy Assistance Program, Child Care Subsidy, or Refugee Resettlement Program is automatically financially eligible for MHCP.

The services coordinator must consult with Central Office staff regarding eligibility for children who are covered under the subsidized adoption program.

2-004.01A Eligibility Verification: The services coordinator taking the application must verify eligibility for Department-administered programs by collateral contacts within the Department, by viewing the client's Nebraska Medicaid Card (eligibility card), or by viewing or printing a Departmental computer screen that shows current Medicaid eligibility or eligibility for another Departmental program (see 467 NAC 2-004.01). The services coordinator must note the contact in the narrative case record.

2-004.01B MA With Excess: If an MHCP-eligible client is also eligible for medical assistance (MA) with excess, the services coordinator must consider the MHCP-eligible client ineligible for Medicaid when authorizing services. Note: Any MHCP payment must be counted toward the spenddown. Once the spenddown is met, the services coordinator must consider the MHCP-eligible client as Medicaid-eligible when authorizing MHCP services. Remains in section 003.04 as modified

2-004.01C Application for Other Programs: During the application process, the services coordinator must refer the client to other programs for which the client may be eligible. The client, parent(s), or guardian must apply for medical services available through other programs, including Medicaid, which access federal funds. If not eligible, the client, parents, or guardian must provide a copy of the notice of denial to the services coordinator. The services coordinator may substitute his/her knowledge of other programs for a notice of denial when it appears the client is not eligible for other programs; this must be documented in the case file. The services coordinator may document verbal inter-agency communication in the narrative. Failure to apply for other programs during the application process is grounds for rejecting or closing the case. Remains in section 003 as modified

2-004.02 Family: Family means a unit consisting of one or more adults (individuals 19 or older) and children, if any, related by blood, marriage, or adoption who reside in the same household. An unborn child may be included if proof of pregnancy is obtained. The following are considered separate families:

1. Related adults other than spouses and unrelated adults who reside together;
2. Children living with non-legally responsible relatives; and
3. Emancipated minors.

An individual age 19 or older living at home is considered a separate family unit. The services coordinator must consider only the individual's income and resources. Family support is considered contributions.

2-004.03 Financial Eligibility Determination: To determine financial eligibility, the services coordinator must consider countable income and resources, minus deductions, in comparison to MHCP's financial criteria. If the client exceeds the criteria, s/he may be eligible "with a financial margin." The financial margin is 25 percent of the amount by which the client exceeds MHCP's financial criteria, minus allowable deductions from that amount (see 467 NAC 2-004.06). The client must spend or obligate the financial margin for medical care for the client before MHCP begins to pay for services. Remains in section 003.02 as modified

The services coordinator must determine financial eligibility using financial information from appropriate forms and income tax forms for the self-employed person. The amounts used to determine financial eligibility are those declared on the application or income tax forms. The services coordinator must contact MHCP Central Office staff in cases where tax forms are not available for self-employed.

2-004.03A Sources of Income: When determining eligibility, the services coordinator must consider the following sources of income:

2-004.03A1 Irregular Income: Irregular income is income, earned or unearned, which varies in amount from month to month or which is received at irregular intervals. This may be due to irregular employment, but even when an individual works regularly, the income may be irregular because of factors such as seasonal increases or decreases in employment and earnings. The following are types of irregular income:

1. Day labor; and
2. Sales work on commission basis.

The services coordinator must use an average of amounts received during the last year, if available, to project future income unless there has been a significant change. Note: The average amount calculated by the services coordinator applies to the entire year, unless there is a significant change in irregular income.

Small, irregular earnings which are not computable or predictable are not considered.

2-004.03A2 In-Kind Income: In-kind income is any non-monetary consideration received by a client in place of income for services provided or as payment of an obligation, such as rent-free housing or farming or as a minister.

2-004.03A3 Lump Sum Income: Lump sum income is money received on a one-time basis. The services coordinator must add the amount of the lump sum to the yearly income to determine financial eligibility. Lump sum income includes:

1. Estates;
2. Retirement pensions which are not re-invested in other retirement accounts;

3. Inheritances or payments received from insurance; and
4. Child support or Social Security (contact Central Office for assistance in considering unusual lump sum payments).

2-004.03A4 Earned Income: Earned income is money received from wages, tips, salary, commissions, self-employment, or items of need received in lieu of wages. Earned income includes:

1. Gross wages/salary – total money earnings received for work as an employee, including wages, salary, armed forces pay, earnings through the Job Support Program, work-study, vocational rehabilitation incentive pay, commissions, tips, piece rate payments, and cash bonuses earned before deductions are made for taxes, bonds, pensions, union dues, and similar purposes.
2. Military allotments (i.e., additional income for spouse, dependants, etc.)
3. *Net income from farm self-employment – gross income minus operating expenses from the operation of a farm received by a client or parent(s) as an owner, renter, or sharecropper. Gross income includes the value of all products sold, government payments, money received from the rental of farm equipment to others, and incidental receipts from the sale of wood, sand, gravel, and similar items. Operating expenses include cost of feed, fertilizer, seed, and other farming supplies, cash wages paid to farmhands, depreciation and interest, cash rent, farm building repairs, property taxes (not state and federal income taxes), and similar expenses. The value of fuel, food or other farm products used for family living is not included as part of net income.
4. *Net income from non-farm self-employment – gross income minus expenses from one's own business, professional enterprise, or partnership. Gross income includes the value of all goods sold and services rendered. Expenses include costs of goods purchased, rent, heat, light, power, depreciation and interest charges, wages and salaries paid, property taxes (not personal income taxes), and similar costs. The value of salable merchandise consumed by the proprietors of retail stores is not included as part of net income.

Individuals with self-employment income must submit a complete copy of the previous year's federal income tax return including all schedules any time they complete the application or when requested.

2-004.03A5 Unearned Income: Unearned income includes but is not limited to

1. Supplemental Security Income (SSI);

2. Social Security – Social Security pensions, survivor's benefits, and permanent disability insurance payments made by the Social Security Administration and Railroad Retirement payments prior to deductions for medical insurance;
3. Dividends – includes dividends from stockholdings or membership in associations;
4. Interest – on savings or bonds, averaged over the period earned;
5. *Rentals – net income from rental of house, store, or other property;
6. Net land lease income;
7. Boarders – gross payments from boarders or lodgers (if self-employed, see item 4 under 467 NAC 2-004.03A4);
8. Royalties – net royalties;
9. Retirement pensions – retirement or pension benefits paid to a retired person or his/her survivors by a former employer or by a union, either directly or through an insurance company;
10. Veteran's pensions – money paid by the Veteran's Administration to disabled members of the armed forces or to survivors of deceased veterans, subsistence allowances paid to veterans for education and on-the-job training, and "refunds" paid to ex-servicemen as G.I. insurance premiums;
11. Contributions (i.e., family support);
12. Unemployment compensation – compensation received from government insurance agencies or private companies during periods of unemployment and any strike benefits received from union funds;
13. Services coordinator's compensation – compensation received from private or public insurance companies for injuries incurred at work;
14. Court-ordered alimony and child support (i.e., cash or direct or indirect payments made to the family);
15. All money contributed for the maintenance of a state or county ward, including foster care payments.

*Note: When calculating net income, if the dollar amount is negative, the services coordinator must count net income as zero.

2-004.03B Income Exclusions: When determining eligibility, the services coordinator must not consider the following sources of income: Remains in section 003.02(A) as modified

1. Money received from participation in the Foster Grandparent Program authorized by the ACTION Program;
2. Money awarded by the Indian Claims Commission or the Court of Claims;
3. Alaska Native Claims Settlement Act payments (to the extent that these payments are exempt from taxation under section 21(a) of the Act);
4. Withdrawals of bank deposits;
5. Money borrowed;
6. Tax refunds;
7. Cash gifts under $500;

8. The value of the coupon allotment under the Food Stamp Act of 1964, as amended;
9. The value of USDA donated foods;
10. The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food service program for children under the National School Lunch Act, as amended;
11. Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
12. Earnings of all children (age 18 and younger);
13. Loans and grants (such as scholarships) obtained and used under conditions that prohibit their use for current living costs;
14. Home produce used for household consumption;
15. Reimbursement from the Senior Companion Program; and
16. Low Income Energy Assistance funds.

2-004.03C: To determine one month's income, the services coordinator must use gross wages for a wage-earner. For a self-employed person, the services coordinator must divide net income from self-employment as entered on the income tax forms by 12.

2-004.03D Self-Employment Income: Individuals with self-employment income must submit a complete copy of the previous year's federal income tax return including all schedules anytime they complete the application or when requested.

2-004.04 Deductions: The services coordinator must deduct the following from countable income: Remains in section 003.02(B)

1. Child support paid;
2. Alimony paid;
3. Child care necessary for employment or education if both parents are employed or receiving education or if one parent is unavailable for child care due to absence or incapacity. Education is defined as enrollment in, and regular attendance at, vocational or educational training to attain a high school or equivalent diploma or an undergraduate degree or certificate designed to fit him/her for paid employment. This excludes students pursuing second undergraduate degrees, second certificates, or any post-graduate schooling;
4. Tuition and books for family members attending school (excluding private elementary and secondary schools and students pursuing second undergraduate degrees, second certificates, or any post-graduate schooling);
5. Medical expenses for the entire family, including medical insurance premiums, paid within the 12 months preceding the date of application.

2-004.04A Medical Expenses: Expenses allowed for the previous year's financial margin are not counted for the current year's medical expenses (see 467 NAC 2-004.06). The services coordinator must subtract the expenses allowed as declared on the previous year's application forms. Remains in section 003.02(B)(i) as modified

2-004.05 Financial Guidelines: The services coordinator must compare the family's countable income minus any deductions, to MHCP's financial criteria:

Financial eligibility through MHCP is available to children with special health care needs who medically qualify if the family income is at or below 185 percent of the federal poverty level for the appropriate family size. Remains in section 003.02 as modified

2-004.06 Financial Margin: If the family's income minus deductions exceed MHCP's financial criteria, the services coordinator must calculate the client's financial margin. The financial margin is 25 percent of the amount which exceeds the guidelines. Remains in section 003.02(D) as modified

2-004.06A Financial Margin Deductions: The services coordinator must deduct the following from the financial margin: Remains in section 003.02(D)(i)

1. Unpaid medical bills for the client not included in the previous year's medical allowance. Note: Paid medical bills are considered under 467 NAC 2-004.04, item 5;
2. Projected travel and lodging costs at state employee rates for specialized medical care;
3. Actual funeral expenses of the client; and
4. Projected cost of child care for siblings while the client is hospitalized or receiving medical services.

If the services coordinator finds other disability-related expenses not listed, s/he must consult the Central Office.

The services coordinator must compare the amount remaining after all applicable deductions are subtracted from the margin to the projected cost of medical care for the client for the next year. The services coordinator may consult MHCP Central Office staff to determine the projected cost of care. The services coordinator must consider how much of the margin will be paid for by any third party. If the amount remaining is more than the projected cost of care, the applicant is ineligible.

If the projected cost of care is more than the remaining amount, the family must spend or obligate the remaining amount of the financial margin for medical care for the client before MHCP begins to pay. Remains in section 003.02(D) as modified

The services coordinator must determine the client financially ineligible if it appears that the margin will not be met. The services coordinator must reject or close the case as appropriate on the computerized system.

2-004.07 Redetermination of Eligibility: Redetermination of financial eligibility is required every 12 months beginning one year from the case action date. For each annual review, the services coordinator must notify the client, parent(s), or legal guardian by letter that the redetermination of eligibility is due in 30 days. If no response is received within 30 days, the services coordinator must send a second notice, allowing an additional 30 days. If no response is received within the second 30-day period, the services coordinator must make every attempt at a personal contact to advise the client, parent(s) or legal guardian of closing the case, then close the case, effective up to 30 days after the last review was due. Remains in section 003.03 as modified

The services coordinator must complete necessary redetermination forms and enter appropriate information into the computerized system.

The services coordinator must complete a redetermination of eligibility when information is obtained about changes in a client's circumstances that may change his/her eligibility. The services coordinator must complete this review as soon as possible within 30 days after receiving the information. Remains in section 003.03 as modified

2-004.07A Eligibility Redetermination When Other HHSS Program Eligibility is Verified: When the client's eligibility for another HHS program is verified by collateral contacts within the Department, by viewing or printing a HHS computer screen that shows current Medicaid eligibility or eligibility for another HHS program (see 467 NAC 2-004.01), the family need not complete another application. The services coordinator must note the methods of verification in the narrative case record. This action and procedure serves as the MHCP eligibility redetermination for clients who are eligible for other HHS programs.

2-005 Case Action Section was rewritten entirely and are now sections 004 and 005 in the proposed regulations with the heading name, “Notices”.

2-005.01 Certification: The services coordinator must determine eligibility within 10 working days after all financial and medical eligibility information is received. The services coordinator must certify an applicant who has been determined medically and financially eligible for a plan of medical care on the computerized system. The services coordinator must notify the parents, client, or guardian of certification for MHCP services by letter. The services coordinator must notify appropriate MHCP-contracted providers of certification and authorization to provide specified care.

2-005.01A Certification Date: The certification date is the effective date of eligibility. See 467 NAC 4-000 ff. for specifics for each service.

2-005.02 Denials: The services coordinator must deny applications or referrals for individuals determined ineligible for MHCP, based on the following reasons:

1. Diagnosis which is not covered by MHCP;
2. No active treatment;
3. Insufficient medical need;
4. Financial ineligibility;
5. The family's or guardian's decision to provide care privately;
6. Lack of cooperation;
7. Failure to apply after the client was referred for services (see 467 NAC 2-002.01C);
8. The client is over age 21;
9. Failure to complete the application; or
10. Care covered by other programs.

Within five working days after the rejection decision, the services coordinator must notify the client, refer him/her to other appropriate programs, and record the rejection on the computerized system.

2-005.03 Closings: The services coordinator must close an MHCP case when -

1. The client has received maximum benefit as determined by the medical consultant;
2. The parents, client, or guardian desire private care;
3. The parent, guardian, or client is not interested in further services;
4. The client reaches age 21 (Exception: See the Genetically Handicapped Person's Program at 467 NAC 6-000 ff.);
5. The client dies;
6. The client moves from Nebraska;
7. The client becomes financially ineligible;
8. The client fails to complete the yearly redetermination of eligibility (see 467 NAC 2-004.07);
9. The service has been discontinued;
10. The client fails to cooperate with MHCP regulations and policies;
11. The client is institutionalized; or
12. The client's needs are covered by other programs.

The services coordinator must close the case on the computerized system. The services coordinator must provide written notice to the parent, guardian, or child at least ten days before the effective date of closing. This notice must include information about -

1. The effective date;
2. The right to appeal; and
3. Reasons for closing and citation of manual reference.

2-006 Transfer of Cases

2-006.01 From One MHCP Services Coordinator to Another: When a case is transferred from one MHCP services coordinator to another, the MHCP services coordinator must send all case files to the new MHCP services coordinator (wherever located) and enter the transfer information into the computerized system.

Note: If the child resides in a different service area than the parent(s) or guardian, the case remains the responsibility of the office in the service area where the parent(s) or guardian reside.

2-006.02 To Another State: When a client moves to another state, the services coordinator must attempt to obtain the new address and contact the Central Office staff for information for the Children with Special Health Care Needs Program in that state. MHCP Service Coordinators must arrange the transfer of the case to the agency which provides Title V services in the new state of residence.

2-006.03 From Another State To Nebraska: When MHCP staff learn of a client who has moved to Nebraska and has been receiving Title V services elsewhere, they must notify the appropriate services coordinator and send any information received to the services coordinator. The services coordinator must contact the client's family and inform them of services available in Nebraska. An application is required if the client wishes to receive services in Nebraska. Information sent by the Title V office in the former state of residence may be used as a referral.

2-007 Record Retention: Four years after the date the case is closed staff may destroy the social and financial information of the case. The services coordinator must copy the computerized system screens and send the copies and all medical information to the MHCP Central Office.

MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

SERVICE & DEVICE APPLICATION

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Name of Person with Disability		Name of Parent/Guardian/Representative	
Birthdate	Sex ❑ Male ❑ Female	Home Phone ( )	Work Phone ( )
Social Security Number		May we call you at work? ❑ Yes ❑ No	
Address		Directions to your home:	
City State Zip			
County		Describe the disability (diagnosis) & limitations	
Mailing Address if Different		Who is your primary care physician?	

Please indicate the race of the person with the disability. Please check one.
OPTIONAL: This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

❑ White ❑ American Indian ❑ Orient/Pacific Islander ❑ Black/African-American
❑ Hispanic/Mexican American ❑ Other (Specify) _____

HOUSEHOLD MEMBERS

NAME (First Name, Middle Initial, Last Name)	Relationship to person listed above	Sex	Social Security Number	Birth Date (Month, Day, Year)
		M F		
		M F		
		M F		
		M F		
		M F		
		M F		
		M F		

Tell Us About Any Health Insurance You Already Have: Tell us the name of your insurance company, the policy number and the insured person's name on the policy. Attach additional sheets if needed.

Insurance Company	Monthly Premium Amount	Policy Number or Group Plan Number	Type of Coverage (HMO, full coverage, vision, etc.)	Who is Covered by Policy?

Describe briefly any deductibles/co-pays/preexisting conditions:

Has the absent parent(s) of any child(ren) age 18 or younger been ordered by the court to pay for the medical care of the child(ren) and/or to include them on his or her health insurance? ❑ Yes ❑ No If Yes, please provide the following information:

Name(s) of Child(ren) Covered Under Policy	Name and Address of the Insurance Company	Policy Number

FINANCIAL INFORMATION: List the amount of income you receive (i.e. you family) from each of the sources below. Single adults (19 years of age or older) should list only your income.

Gross Income (your income before deductions)	Amount	How Often Received	Who Receives it	Employer
Wages, overtime, bonuses, commissions, etc. (Paystubs may be required for verification)				
Self-Employment (Complete copy of Federal IRS 1040 is required)				
Interest, dividends, money from investments, and capital gains				
Social Security Retirement				
Social Security (SSI)				
Social Security Disability				
Veteran's Benefits				
Pensions				
Retirement, Keogh Accounts, IRA's, etc.				
Inheritance, estates, trust funds, etc.				
Aid to Aged, Blind & Disabled (State Supplemental Check)				
Aid to Dependent Children (ADC)				
Alimony/Child Support				
Compensation (worker's & unemployment)				
Rental income & boarders				
Educational grants specifically for living expenses				
Contributions/family support				
Miscellaneous (insurance settlements, lottery winnings, and other, please describe).				

Assets			
Cash on hand			
Checking/Savings Account			
Stocks/Bonds			
C.D.'s			
Other liquid assets that can be converted without penalty			

EXPENSES:

Child care costs for employment (per month)	Child support/alimony paid (per month)
Tuition/books paid out-of-pocket for 1st degree	

Please itemize all dental and medical expenses/medical equipment/home modifications/medical transportation/lodging for the last 12 months for the entire family. Attach an additional sheet if more entries are necessary. DO NOT ATTACH BILLS. **Include insurance premiums paid in the last 12 months.**

Family Member Who Received the Care	Physician, Hospital, Dentist, etc. who Provided the Care	Date of Service	Total Bill	Amount Paid by Insurance	Amount Paid by Family	Amount Owed
	TOTAL					

I AGREE TO:

1. Notify the Medically Handicapped Children's Program worker before receiving services at scheduled appointments and laboratory tests;
2. Keep all appointments for medical care and medical examinations;
3. Follow the individual medical treatment plan;
4. Notify the Medically Handicapped Children's Program worker of emergency care within five working days;
5. Obligate payment for that part of the treatment which has been agreed upon by the Medically Handicapped Children's Program and the client or has been determined to be the client's responsibility;
6. Assume responsibility for general health care for the client; and
7. Allow the Department of Health and Human Services to release and obtain any medical information for the purpose of medical treatment.

I believe the information I give is true, correct, and complete. I know the penalty for hiding information or giving false information. I certify under penalty of perjury that all answers I give are correct and complete to the best of my knowledge. I understand and agree to provide documentation to prove what I say.

Signature or mark of applicant, representative or legal guardian	Date
Signature or mark of spouse, other parent or stepparent in the home	Date
Witness to the mark of applicant	Date

Services and Devices Requested

Check all the areas below that apply:

- ❑ Home Modification
- ❑ Personal Attendant
- ❑ Meals and Lodging
- ❑ Home Health Care
- ❑ Housekeeping Service
- ❑ Prescriptions
- ❑ Respite Care
- ❑ Special Equipment
- ❑ Transportation
- ❑ Other _____

Housing

Check all that apply:

- ❑ Owner
- ❑ Renter

If you are a renter fill in the following:

Landlord _____

Address _____

City/State/Zip _____

Phone ( ) _____

- ❑ Nursing Home
- ❑ Foster Home/Adult Family Home
- ❑ Group Home/Community Residence
- ❑ Living with adult/adult children
- ❑ Homeless
- ❑ Other _____

Type

- ❑ Single Family Unit
- ❑ Multi Family Unit # _____ of units
- ❑ Mobile Home
- ❑ Other _____

Programs

Check the programs you have received assistance from:

- ❑ League of Human Dignity, Barrier Removal Program
- ❑ Housing & Urban Development, Section 203
- ❑ Making Homes Accessible
- ❑ Rural Development, Section 502
- ❑ Rural Development, Section 504
- ❑ Weatherization

Personal

Check all that apply:

Veteran Status

- ❑ Veteran
  - ○ The person with disability is a veteran.
  - ○ The spouse of person with disability is a veteran.
  - ○ The parent of person with disability is a veteran.
- ❑ Veteran was in military service during a war.
- ❑ Veteran has a service-connected disability.
- ❑ Veteran is a resident of Nebraska

Dates of Service _____

Citizen of U.S.

❑ Yes ❑ No

Insurance

- ❑ Private Health Insurance
  Specify: _____
- ❑ Medical Assistance/Medicaid
- ❑ Medicare

Assistance

Check below any of the following that have provided assistance to you (i.e. information, referral, or funding) during the last year:

- ❑ Hotline for Disability Services
- ❑ Independent Living Center
- ❑ Nebraska Assistive Technology Project
- ❑ Nebraska Commission for the Deaf & Hard of Hearing
  - ○ Decoder Loan
  - ○ TDD Loan
- ❑ Nebraska Health & Human Services
  - ○ Aging
  - ○ Developmental Disabilities
  - ○ Disabled Persons and Family Support
  - ○ Medicaid Waiver
  - ○ Medically Handicapped Children's Program
  - ○ Mental Health Services
  - ○ Services for the Visually Impaired
  - ○ Social Services Block Grant
- ❑ Nebraska Veterans' Aid Fund
- ❑ Paralyzed Veterans of America Education Center
- ❑ United Cerebral Palsy of Nebraska
- ❑ Veterans Service Office
- ❑ Vocational Rehabilitation Services
- ❑ Other _____

Release/Agreement Form

- ❑ I verify that the information provided on this application is correct and complete.
- ❑ I understand that whenever changes occur in the information provided, I need to report them immediately to one of the agency/agencies helping me obtain devices or services.
- ❑ I understand I have the right to appeal if I am not satisfied with an agency's action.
- ❑ I understand that this is a multi-agency form. The agencies/programs listed below may contact each other to determine my financial eligibility for their programs, and may verify my need for the support for which I have applied. I authorize the release of this information to be used for referral/services for which it is determined I may be eligible. It is my understanding that this information will be held confidential by all the agencies listed.
  - Client Assistance Program
  - Hotline for Disability Services
  - Independent Living Centers (League of Human Dignity, Panhandle Independent Living Services, Center for Independent Living of Central Nebraska, Inc.)
  - Making Homes Accessible Program
  - Nebraska Advocacy Services
  - Nebraska Assistive Technology Project
  - Nebraska Assistive Technology Project, Peer Support Network
  - Nebraska Childfind
  - Nebraska Commission for the Deaf & Hard of Hearing
  - Nebraska Department of Health & Human Services (i.e. Aging, Developmental Disabilities, Disabled Persons & Family Support, Medically Handicapped Children's Program, Special Requirements, SSI-Disabled Children's Program, etc.)
  - Nebraska Easter Seal Society
  - Nebraska Department of Veterans' Affairs, Nebraska Veterans' Aid Fund
  - Nebraska Educational Assistive Technology (NEAT) Center
  - Paralyzed Veterans of America Educational Center
  - The Arc of Nebraska
  - United Cerebral Palsy of Nebraska
  - Vocational Rehabilitation
  - Other _____

Signature of Applicant (or Guardian)	Date

Return this form to:

~~CHAPTER 3-000 RESERVED~~ Chapter 3 is no longer reserved. Chapter 4 was moved to Chapter 3 in the proposed regulations.

TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 3 DIAGNOSES AND SERVICES FOR THE MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

001. SPECIALIZED MEDICAL CARE. Specialized medical care is covered, according to each diagnoses' service components, for eligible recipients. The medical care must be outlined in the individual medical treatment plan that is developed and signed by a health care professional. The specialized medical care must be directly related to the medically eligible diagnosis. Routine, general health care is not a covered service.

001.01 LOCATION OF SERVICES. Recipients are encouraged to use medical providers and facilities closest to their place of residence. If a medical provider or facility is available closer to the residence and the recipient chooses one further away, the Department is not obligated to pay for services.

001.02 SERVICES PROVIDED OUTSIDE NEBRASKA. Specialized medical care received from Nebraska medical providers is covered by the Program. The recipient, parent, or legal guardian must obtain prior approval from the Department for all non-emergency services outside of Nebraska. In the following situations, the Department may approve specialized medical care to be provided outside Nebraska:

(A) A medical service is not available in Nebraska but is available in another state. Written documentation must be provided by the medical provider to explain the medical service requested and that the service is not available in Nebraska;

(B) Emergency situations that arise while the recipient is visiting in another state and the recipient's health would be jeopardized if care was postponed until the recipient returned to Nebraska. Medical services are covered as if it were provided in Nebraska. Emergency services may be reviewed by the medical consultant. Emergency services will be covered up to five days; or

(C) The medical service is more accessible in another state.

001.03 NON COVERED SERVICES. Services and care of recipients residing in an institution setting are not covered. Funds are not used to cover fees for long term care facilities, including skilled nursing facilities or intermediate care facilities.

002. ASTHMA DIAGNOSIS AND SERVICES. This service provides treatment for severe, persistent asthma in recipients.

002.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Applicants and recipients must meet specific criteria for severe, persistent or moderate, persistent with several complicating

factors. Persistent asthma is having more than two episodes of asthma symptoms per week. Severe asthma is continual daily symptoms and frequent nightly symptoms prior to treatment. Daily symptoms or more per month nightly symptoms fall into the more moderate category. Life threatening episodes, frequent hospitalizations, evidence of chronic lung disease, evidence of the disease adversely affecting every day functioning, including psychological disturbances secondary to the disease will all be taken into account.

002.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for asthma.

002.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

002.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

003. BURNS DIAGNOSIS AND SERVICES This service provides treatment for serious burn injuries through the burn centers in the metro-area.

003.01 MEDICAL ELIGIBILITY CONSIDERATIONS. When determining eligibility, the medical consultant takes into account the referring physician's report of the burn injury, the degree of the burn, percentage of body surface burned, and the physical location of the burn.

003.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for burns.

003.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

003.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

004. CEREBRAL PALSY DIAGNOSIS AND SERVICES. This service provides screening and treatment for applicants or recipients who have residual alterations in motor function as a result of brain or brain stem damage or spinal cord injury from any cause.

004.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The most common diagnoses covered are quadriplegia, hemiplegia, diplegia, and paraplegia. Other applicants and recipients with motor difficulties may be eligible as authorized by the medical consultant or clinic team.

004.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for cerebral palsy. If a Department sponsored medical clinic is available in the applicant or recipient's community, the clinic evaluation may take the place of the medical consultant review for eligibility determination.

004.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met. If applicant is utilizing a Department sponsored medical clinic for medical eligibility, the certification date is the date the applicant was first seen at the medical clinic.

004.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

005. CRANIOFACIAL DIAGNOSIS AND SERVICES. This service provides treatment for recipients with craniofacial anomalies.

005.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Eligible diagnosis include bilateral, unilateral, complete, and incomplete cleft lip and cleft palate. Other craniofacial anomalies may be considered. Department sponsored medical clinics may be offered in the applicant or recipient's community to provide diagnostic evaluations.

005.01(A) MEDICAL ELIGIBILITY DETERMINATION. The Department determines medical eligibility for craniofacial diagnosis. The medical consultant only determines eligibility for craniofacial diagnosis which falls under the "other craniofacial anomalies".

005.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

005.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

006. CYSTIC FIBROSIS DIAGNOSIS AND SERVICES. This service provides treatment for cystic fibrosis which is commonly associated with the pancreas, respiratory system, and sweat glands.

006.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The only eligible diagnosis is cystic fibrosis, fibrocystic disease. Cystic fibrosis is an inherited disease of the exocrine glands.

006.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for cystic fibrosis.

006.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

006.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

007. DIABETES DIAGNOSIS AND SERVICES. This service provides treatment for diabetes mellitus.

007.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The only eligible diagnosis is diabetes mellitus, Type I or Type II.

007.01(A) MEDICAL ELIGIBILITY DETERMINATION. The Department determines medical eligibility for diabetes diagnosis. Medical consultant does not determine medical eligibility.

007.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

007.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

008. EYE DIAGNOSIS AND SERVICES. This service provides treatment for eye defects which include the need for surgeries.

008.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The most common diagnoses covered are ptosis, exotropia, congenital cataracts, glaucoma, and blocked tear ducts. Medical eligibility is dependent upon the need for surgery.

008.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for eye diagnosis.

008.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

008.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

009. HEARING DIAGNOSIS AND SERVICES. This service provides treatment for recipients with significant hearing loss requiring amplification or have a condition which may result in a hearing loss. The purpose is to improve hearing acuity and prevent further hearing loss.

009.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The hearing diagnosis may be used to fill the service gaps for infants that need additional diagnostic, medical treatment planning, and medical treatment services beyond the newborn hearing screening phase, subject to local school system's responsibilities. Eligibility for hearing services must be evidenced by a permanent hearing loss or a medical condition resulting in a permanent hearing loss. Medical conditions which include hearing loss but respond to medication and placement of tube, myringotomy, and usually result in normal hearing are considered acute conditions which are not medically eligible.

009.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for hearing.

009.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

009.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

010. HEART DIAGNOSIS AND SERVICES. This service provides treatment for congenital and acquired heart disease.

010.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The most common diagnoses covered are Tetralogy of Fallot, transposition of the great vessels, coarctation of the aorta, mitral/aortic valve stenosis, ventricular septal defect, and atrial septal defect. Other chronic heart conditions may be considered.

010.01(A) MEDICAL ELIGIBILITY DETERMINATION. The Department determines medical eligibility for heart diagnosis. The medical consultant only determines eligibility for heart diagnosis which falls under the “other diagnoses may be considered” category.

010.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

010.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

011. HEMOPHILIA DIAGNOSIS AND SERVICES. This service provides treatment for hemophilia and certain bleeding disorders.

011.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Hemophilia is a genetically transmitted disease caused by deficiency of an antihemophilic globulin, Factor VIII. Bleeding episodes may occur due to minor injuries, surgeries, dental work, and other procedures and may require extensive treatment. Medically eligible diagnoses are congenital Factor VII and severe Factor IX disorders, such as hemophilia and Christmas disease.

011.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for hemophilia diagnosis.

011.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

011.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

012. MAJOR MEDICAL DIAGNOSIS AND SERVICES. This service provides treatment for diagnoses determined to be congenital, chronic, or prolonged, and in need of active treatment. If the applicant or recipient’s diagnosis does not meet criteria for other services, the applicant or recipient may be considered for this service.

012.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Common diagnoses covered are Addison’s disease, Turner’s syndrome, hypothyroidism, esophageal strictures, imperforate anus, tracheoesophageal fistula, choanal atresia, enterocolitis, Hirschsprung’s disease, aplastic anemia, gastroschisis, growth hormone deficiency, phenylketonuria, and duodenal atresia. Medically eligible immunological deficiencies are congenital hypogammaglobinemia, acquired hypogammaglobinemia, DiGeorge’s syndrome, severe combined immunodeficiency, ataxia-telangiectasia syndrome, Wiskott-Aldrich syndrome,

chronic granulomatous disease, Chediak-Higashi syndrome, and Kostmann's syndrome. Complement deficiencies may be considered. Not covered are growth hormone transplants of bone marrow and thymus or selective IgA deficiency, chronic mucocutaneous candidiasis, hyper IgE syndrome, and Quie-Hill syndrome.

012.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for major medical.

012.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

012.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

013. MIDLINE NEUROLOGICAL DEFECT DIAGNOSIS AND SERVICES. This service provides treatment for spina bifida, meningomyelocele, or other central nervous system neurological defects.

013.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Common diagnoses covered are spina bifida aperta with hydrocephalus, spina bifida aperta without hydrocephalus, spina bifida occulta, congenital hydrocephalus, encephalocele, obstructive hydrocephalus – acquired, hydranencephaly, spinal cord lesion, and craniosynostosis requiring surgery. Other central nervous system neurological defects may be considered.

013.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for midline neurological defect.

013.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

013.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

014. NEOPLASM DIAGNOSIS AND SERVICES. This service provides treatment for neoplastic (cancerous) diseases or non-malignant tumors when the tumor is potentially disabling.

014.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Common diagnoses covered are leukemia, lymphoma, Ewing's sarcoma, Wilm's tumor, rhabdomyosarcoma, neuroblastoma, astrocytoma, and osteogenic sarcoma. Other brain tumors that are potentially disabling may be considered.

014.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for neoplasm.

014.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

014.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

015. NEUROLOGICAL DIAGNOSIS AND SERVICES. This service provides treatment for neurological conditions.

015.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Common diagnoses covered are seizures, subdural hematoma, encephalocele, and Guillain-Barre syndrome. Seizures are not a covered diagnosis during a newborn's initial hospitalization at birth. Other chronic neurological conditions may be considered.

015.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for neurological.

015.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

015.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

016. ORTHOPEDIC DIAGNOSIS AND SERVICES. This service provides treatment for general orthopedic problems, congenital or acquired, excluding recent fractures.

016.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Common diagnoses covered are talipes equinovarus, arthrogryposis, Legg-Calve-Perthes disease, congenital dislocation of the hip, and the need for prostheses. Spinal cord injuries may be considered for rehabilitative care. Additional diagnoses that may be considered are tibial torsion, bowed legs, torn medial meniscus, leg length discrepancy, and fractures that have not healed properly. Other severe and chronic orthopedic conditions may be considered.

016.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for orthopedic.

016.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

016.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

017. PREMATURE BIRTHS DIAGNOSIS AND SERVICES. This service provides treatment for certain premature infants with medical complications and must be referred to other available resources or programs that assist with this population.

017.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Medical eligibility is based on seriousness of the condition for each applicant or recipient. Covered diagnoses may include bronchopulmonary dysplasia and hyaline membrane disease or respiratory distress syndrome when the infant has been on mechanical ventilation for more than five days. Certain other conditions associated with prematurity may be considered. Diagnoses not covered are

meconium aspiration, neonatal sepsis, hypoglycemia, and neonatal meningitis. Low birth weight and gestational age alone are not medically eligible. Hospitalizations for acute care or weight gain are not medically eligible.

017.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for premature births. All inpatient hospitalization discharge summaries are required.

017.01(B) CERTIFICATION DATE. The certification date is the date of birth, if referred within 30 days of the date of birth, once medical and financial eligibility is met. If the referral is not made within the 30 days of birth, the certification date is the date of referral, once medical and financial eligibility is met.

017.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

018. RHEUMATOID ARTHRITIS DIAGNOSIS AND SERVICES. This service provides treatment for juvenile rheumatoid arthritis and related conditions.

018.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The covered diagnosis is juvenile rheumatoid arthritis. Other related conditions may be considered.

018.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for rheumatoid arthritis.

018.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

018.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

019. SCOLIOSIS DIAGNOSIS AND SERVICES. This service provides treatment for anomalies of the spine.

019.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Eligible diagnoses are congenital scoliosis, spondylolisthesis, and congenital absence of vertebra, hemivertebra, and congenital fusion of the spine. Other conditions of the spine may be considered.

019.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for scoliosis.

019.01(B) CERTIFICATION DATE. The certification date is the referral date, once medical and financial eligibility is met.

019.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

020. UROLOGY DIAGNOSIS AND SERVICES. This service provides treatment for kidney, urinary, and genital anomalies determined to be chronic and disabling or potentially disabling and active treatment is necessary.

020.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Covered diagnoses are exstrophy of the bladder, bilateral ureteral reflux, extensive hypospadias, ambiguous genitalia, and hydronephrosis. Other related diagnoses may be considered. Eligibility ends when dialysis or transplant is required – other public programs are available for this stage of disease.

020.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for urology.

020.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

020.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 4 DIAGNOSES AND SERVICES FOR THE GENETICALLY HANDICAPPED PERSONS PROGRAM

001. SPECIALIZED MEDICAL CARE. Specialized medical care is covered, according to each diagnoses' service components, for eligible recipients age 21 years and older. The medical care must be outlined in the individual medical treatment plan that is developed and signed by a health care professional. The specialized medical care must be directly related to the medically eligible diagnosis. Routine, general health care is not a covered service.

001.01 LOCATION OF SERVICES. Recipients are encouraged to use medical providers and facilities closest to their place of residence. If a medical provider or facility is available closer to the residence and the recipient chooses one further away, the Department is not obligated to pay for services.

001.02 SERVICES PROVIDED OUTSIDE NEBRASKA. Specialized medical care received from Nebraska medical providers is covered by the Program. The recipient, parent, or legal guardian must obtain prior approval from the Department for all non-emergency services outside of Nebraska. In the following situations, the Department may approve specialized medical care to be provided outside Nebraska:

(A) A medical service is not available in Nebraska but is available in another state. Written documentation must be provided by the medical provider to explain the medical service requested and that the service is not available in Nebraska;

(B) Emergency situations that arise while the recipient is visiting in another state and the recipient's health would be jeopardized if care was postponed until the recipient returned to Nebraska. Medical services are covered as if it were provided in Nebraska. Emergency services may be reviewed by the medical consultant. Emergency services will be covered up to five days; or

(C) The medical service is more accessible in another state.

001.03 NON COVERED SERVICES. Services and care of recipients residing in an institution setting are not covered. Funds are not used to cover fees for long term care facilities, including skilled nursing facilities, and intermediate care facilities.

002. CYSTIC FIBROSIS DIAGNOSIS AND SERVICES. This service provides treatment for cystic fibrosis which is commonly associated with pancreas, respiratory system and sweat glands.

002.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The only eligible diagnosis is cystic fibrosis fibrocystic disease. Cystic fibrosis is an inherited disease of the exocrine glands.

002.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for cystic fibrosis.

002.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

002.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

003. HEMOPHILIA DIAGNOSIS AND SERVICES. This service provides treatment for hemophilia and certain bleeding disorders.

003.01 MEDICAL ELIGIBILITY CONSIDERATIONS. Hemophilia is a genetically transmitted disease caused by deficiency of an antihemophilic globulin, Factor VIII. Bleeding episodes may occur due to minor injuries, surgeries, dental work, and other procedures and may require extensive treatment. Medically eligible diagnoses are congenital Factor VII and severe Factor IX disorders, such as hemophilia and Christmas disease.

003.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for hemophilia diagnosis.

003.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

003.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

004. SICKLE CELL DISEASE DIAGNOSIS AND SERVICES. This services provides treatment for sickle cell disease – sickle cell anemia.

004.01 MEDICAL ELIGIBILITY CONSIDERATIONS. The only eligible diagnosis is sickle cell disease.

004.01(A) MEDICAL ELIGIBILITY DETERMINATION. The medical consultant determines medical eligibility for sickle cell disease.

004.01(B) CERTIFICATION DATE. The certification date is the date of referral, once medical and financial eligibility is met.

004.02 SERVICE COMPONENTS. Service components may be covered if recommended in the individual medical treatment plan and funds are available.

CHAPTER 4-000 TITLE V SERVICES FOR MEDICALLY HANDICAPPED CHILDREN

4-001 Introduction:

4-001.01 Individual Medical Treatment Plan (IMTP): MHCP provides specialized medical services according to an individual medical treatment plan for each client. The plans are arranged with MHCP-contracted specialists and facilities in Nebraska. Each plan must be initiated by an MHCP-contracted specialist or by an MHCP-approved multi-disciplinary team. Any service not specified in the IMTP must be approved by the MHCP medical consultant in the Central Office before authorization for payment is given. Remains in chapter 3, section 001 as modified

4-001.01A Treatment: Treatment in accordance with the individual medical treatment plan is arranged with MHCP-contracted specialists and/or facilities. Care provided for each client must be directly related to the eligible diagnosis(es), since MHCP does not provide general medical care. Remains in chapter 3, section 001 as modified

4-001.01B Location of Services: MHCP makes every effort to provide the client's care as close as possible to the client's place of residence. The location and number of MHCP-contracted specialists and facilities which are appropriate determines the choice and site for each client's medical care. Remains in chapter 3, section 001.01 as modified

4-001.02 Services Provided Outside Nebraska: MHCP uses resources in Nebraska to provide appropriate services by qualified providers. MHCP may cover specialized care provided outside Nebraska in the following situations: Remains in chapter 3, section 001.02 as modified

1. When the client requires a medical service that is not available in Nebraska but is available in another state;
2. When an emergency arises while the client is visiting in another state and the client's health would be endangered if care was postponed until s/he returned to Nebraska or if s/he traveled to Nebraska;
   Note: When the client receives emergency services outside Nebraska, MHCP covers those services which would normally be covered if provided within the state. The provider must meet that state's licensure laws and regulations and must agree to accept MHCP payment as payment in full for the covered services. All services are subject to review by the MHCP medical consultant. MHCP covers these emergency situations for no more than 10 days; and
3. When the client customarily obtains services in another state because the service is more accessible.

The client, parent(s), or guardian must request prior approval for all non-emergency out-of-state services.

4-001.02A When the Service is Not Available in the State: When the service is not available within the state, the following criteria must be met for approval:

1. An MHCP-contracted provider must provide written documentation as requested by the MHCP medical consultant that the service is not available in Nebraska;
2. The out-of-state provider must meet that state's licensure laws and regulations and must accept MHCP's established fee schedules for services as payment in full;
3. The treatment and services must be considered standard medical practice and must not be of an experimental nature or the subject of a study to establish acceptance as standard medical practice; and
4. The MHCP medical consultant must give specific prior approval for the service.

4-001.03 Transportation: Transportation of clients to and from evaluations, medical services, and related care can be authorized after all resources have been exhausted. MHCP does consider transportation costs in determining financial eligibility (see 467 NAC 2-004 ff.). All transportation requests must be approved through the Central Office. Reimbursement for mileage will be at 20 cents per mile.

4-001.04 Other Covered Services: MHCP may cover adaptive equipment, such as wheelchairs, van lifts, equipment for home use, or standing tables up to $3600 when no other resources are available.

4-001.05 Non-Covered Services

4-001.05A Custodial Care: MHCP does not cover or certify children who require only custodial or medical maintenance care. MHCP provides treatment only for conditions which include a plan of active medical treatment and which can be cured or materially improved. However, the services coordinator may assist families by making appropriate referrals for services.

4-001.06 Chapter Organization: This chapter governs the following Title V MHCP services:

1. Asthma (see 467 NAC 4-002);
2. Burns (see 467 NAC 4-003);
3. Cerebral palsy (see 467 NAC 4-004);
4. Craniofacial Conditions (see 467 NAC 4-010);
5. Cystic fibrosis (see 467 NAC 4-011);
6. Diabetes services (see 467 NAC 4-012);
7. Eye (see 467 NAC 4-013);
8. Hearing (see 467 NAC 4-014);
9. Heart (see 467 NAC 4-015);

10. Hemophilia (see 467 NAC 4-016);
11. Major medical (see 467 NAC 4-017);
12. Mid-line Neurological Defects (see 467 NAC 4-018);
13. Neoplasm (see 467 NAC 4-019);
14. Neurological (see 467 NAC 4-020);
15. Orthopedic: General (see 467 NAC 4-021);
16. Premature births (see 467 NAC 4-023);
17. Rheumatoid arthritis (see 467 NAC 4-024);
18. Scoliosis (see 467 NAC 4-025); and
19. Urology (see 467 NAC 4-026).

Regulations for the Genetically Handicapped Persons' Program are in 467 NAC 5-000. Regulations for the SSI-DCP are in 467 NAC 6-000.

4-002 Asthma Service: This service provides treatment for severe persistent asthma in children. Medical eligibility criteria for this service is designed to include those children with severe persistent asthma. Remains in chapter 3, section 002 as modified

4-002.01 Medical Eligibility: In determining eligibility for this program, the "Guidelines for the Diagnosis and Management of Asthma" disseminated by the National Asthma Education and Prevention Program in 1997 will be the basic outline. The group of children that may qualify for participation in MHCP are those who fit the criteria of severe persistent or moderate persistent with several complicating factors.

Those children with more than two episodes of asthma symptoms per week have persistent asthma. Those children with continual daily symptoms and frequent nightly symptoms prior to treatment fall into the category of severe. Those children with daily symptoms and/or more per month nightly symptoms fall into the more moderate category. Highest priority will be given to those children who have had any life-threatening episodes, have had frequent hospitalizations, have evidence of chronic lung disease, have evidence that the disease is adversely affecting their every day functioning such as missed school days and have evidence of accompanying psychological disturbances secondary to their disease. Remains in chapter 3, section 002.01 as modified

The medical consultant must determine medical eligibility following evaluation by an asthma specialist, considering their input and recommendations. Remains in chapter 3, section 002.01(A) as modified

4-002.02 Clinics/Diagnostic Evaluations: When determined appropriate by MHCP Central Office staff, the client must receive a diagnostic evaluation from a pediatric allergist (or a pediatric pulmonologist when an allergist is not available) or at an MHCP-sponsored clinic for asthma.

4-002.03 Certification Date: When the child is both medically and financially eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 002.01(B) as modified

4-002.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from the Central Office. Remains in chapter 3, section 002.02 as modified

1. Office evaluations for asthma, such as follow-up care with an MHCP contracted pediatric allergist or pediatric pulmonologist or primary care physician as directed by the specialist involved with the child;
2. Laboratory tests, x-rays, cardiopulmonary tests, i.e., lung function tests;
3. Emergency room care as directed by the contracted pediatric specialist;
4. Hospitalizations for asthma under the direct supervision of the pediatric specialist or the primary care physician working in concert with the specialist;

5. Prescribed asthma medication included on the approved list, aerosol treatment and equipment such as nebulizers and spacers;
6. A one-time evaluation of the home environment by an environmental specialist may be paid for when available in the community; and
7. Nutrition services.

If any other service components are recommended in the IMTP, the services coordinator must submit reports to the medical consultant for approval of payment. MHCP Central Office staff must determine coverage.

4-002.05 Specific Providers: Care for asthma is provided primarily by MHCP-contracted pediatric allergists or pediatric pulmonologists. The use of a local physician directly supervised by a pediatric allergist or pediatric pulmonologist is allowed for on-going asthma care with Central Office approval.

4-002.06 Procedures

4-002.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and medical facilities involved in the client's asthma care. Upon receipt of the medical reports, the services coordinator must follow the procedures in 467 NAC 4-002.06B and 4-002.06C.

4-002.06B Referrals From General Physicians or Pediatricians: The services coordinator must submit a referral from a general physician or pediatrician to the Central Office for review. MHCP Central Office staff must determine if a diagnostic evaluation by a pediatric allergist or pediatric pulmonologist is required to determine medical eligibility. If authorization for the diagnostic evaluation is given, the services coordinator must contact the client, parents, or guardian and arrange the appointment. When the appointment is scheduled, the services coordinator must send –

1. An authorization to the pediatric allergist or pulmonologist, authorizing the diagnostic evaluation and requesting that a report be sent to the services coordinator after the evaluation; and
2. A letter to the pediatric allergist or pulmonologist is optional.

The services coordinator must send the reports with results of the evaluation to the Central Office. MHCP Central Office staff must determine medical eligibility and return to the services coordinator with eligibility coding.

If the diagnostic evaluation is not authorized, the services coordinator must notify the client, parents, or guardian that the client is not medically eligible (see 467 NAC 4-024.06D).

4-002.06C Referrals From Pediatric Allergists or Pediatric Pulmonologists: The services coordinator must submit the medical referral to the Central Office for review. After review, MHCP Central Office staff must determine medical eligibility and return the report to the services coordinator with eligibility coding.

Note: If the client lives outside the city where the pediatric allergist or pulmonologist practices, the services coordinator must request Central Office authorization for the client's local physician to provide routine asthma care under the pediatric allergist's or pulmonologist's direction.

4-002.06D Medical Eligibility Notification: If the client is medically eligible, the services coordinator must –

1. Notify the client, parents, or guardian; and
2. Request a financial application.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action on the computerized system.

4-002.06E Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action on the computerized system.

4-002.06F Certification: When the client is financially and medically eligible, the services coordinator must certify the case and –

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, such as the name of the pharmacy and local physician, and arrange the follow-up interview required under 467 NAC 2-002.01A. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact the pharmacy to explain MHCP and billing procedures as appropriate;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;

b. The certification date;
c. Medical care eligible for payment;
d. Authorized providers;
e. Prescribed asthma medications approved by the MHCP medical consultant; and
f. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and laboratory tests (before receiving the services);

4. Send an authorization to the pediatric allergist or pulmonologist with a copy to local physician, if authorized to provide routine care;
5. Send an authorization to the pharmacy, noting that insurance, Medicaid, and/or other third parties must be billed first; and
6. Enter the case action on the computerized system.

4-002.06G Ongoing Services Coordination: The services coordinator must –

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to asthma and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit in the Central Office with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition. Services coordinator should work with asthma specialist if there are any issues of medication compliance;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01 (this may be completed as part of the clinic interview); and
8. Assist families in keeping a running log on each asthma case to record hospitalizations, ER visits and reports of school absenteeism. A copy of this log should be added to the MHCP record once each year;
9. Continue to reassess need for other services; assist and refer as appropriate.

4-003 Burn Service: This service provides treatment for serious burn injuries through the burn centers in Lincoln and Omaha. Remains in chapter 3, section 003 as modified

4-003.01 Medical Eligibility: The MHCP medical consultant must review all referrals for medical eligibility determination based on the referring physician's report of the burn injury. Determining factors are the degree of burn, the percentage of body surface burned, and the physical location of the burn. Remains in chapter 3, section 003.01 and 003.01(A) as modified

4-003.02 Clinics/Diagnostic Evaluations: Diagnostic evaluations are not routinely covered by this service. There are no MHCP-sponsored clinics for this service.

4-003.03 Certification Date: When the client is both financially and medically eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 003.01(B) as modified

4-003.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 003.02 as modified

1. Hospitalizations;
2. Physician services by an MHCP-contracted burn surgeon, and a pediatrician (for inpatient hospital stays only when requested by an MHCP-contracted burn surgeon);
3. Ace or Jobst bandages;
4. Outpatient hospital burn care or office visits to an MHCP-contracted burn surgeon;
5. Physical therapy (only if not covered through the school system);
6. Psychiatric consultation (no ongoing therapy services); and
7. Nutrition services.

If any other service components are recommended in the IMTP, the services coordinator must submit the medical report to the medical consultant for approval of payment. The services coordinator must submit requests for approval of payment for service components not recommended in the IMTP to MHCP Central Office staff. MHCP Central Office staff must determine coverage.

4-003.05 Specific Providers: Covered services must be provided by St. Elizabeth Community Health Center, Children's Memorial Hospital, MHCP-contracted burn surgeons, and other providers approved by the Central Office.

4-003.06 Procedures

4-003.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and/or medical facilities involved in the client's medical care. The services coordinator must send the reports to the medical consultant for a medical eligibility determination. MHCP Central Office staff must determine medical eligibility and return the reports to the services coordinator with eligibility coding.

4-003.06B Medical Referrals: If the services coordinator receives a referral with medical report, s/he must send the report the medical consultant for a medical eligibility decision. After review, MHCP Central Office staff must determine medical eligibility and return the report to the services coordinator with eligibility coding.

4-003.06C Medical Eligibility Notification: After the services coordinator receives the coded medical report and if the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian by letter; and
2. Include a financial application in the letter.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-003.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-003.06E Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01A. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);

4. Send a letter to the physician in charge of care; and
5. Enter the case action into the computerized system.

4-003.06F Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to burns and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01A; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-004 Cerebral Palsy (CP) Service: This service provides screening and treatment for children who have residual alterations in motor function as a result of brain or brain stem damage or spinal cord injury from any cause. Other children with motor difficulties may be appropriate as authorized by the MHCP medical consultant. Remains in chapter 3, sections 004 and 004.01 as modified

4-004.01 Medical Eligibility: The most common diagnoses covered are quadriplegia, hemiplegia, diplegia, and paraplegia. Remains in chapter 3, section 004.01 as modified

4-004.02 Clinics/Diagnostic Evaluations: Each child is initially evaluated by a multi-disciplinary team at an MHCP-sponsored clinic coordinated with the primary care physician. All covered services must be supervised and recommended by the multi-disciplinary team, which is usually composed of a pediatrician, an orthopedist, a physical therapist, an occupational therapist, a nurse, a nutritionist, the family, the services coordinator, and, in some cases, a psychologist.

4-004.03 Certification Date: The certification date is the date the child is first seen at a cerebral palsy clinic or the date of a private evaluation approved by the MHCP Central Office staff. Certification date remains in chapter 3, section 004.01(B) but modified

4-004.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 004.02 as modified

1. Evaluation through the cerebral palsy clinic;
2. Orthopedic x-rays;
3. Braces and splints;
4. Standing frames, walkers, and crutches;
5. Corrective shoes;
6. Orthopedic surgery;
7. Neurologic care, including evaluations with a contracted neurologist, approved seizure medications, blood levels to check seizure medications, and CT scans;
8. Hospitalizations;
9. Nutrition services; and
10. Feeding and swallowing evaluation.

If any other service components are recommended in the IMTP, the services coordinator must submit the medical reports to the medical consultant for approval of payment. The services coordinator must submit requests for approval of payment for service components not recommended in the IMTP to MHCP Central Office staff for approval or coverage.

Note: Maintenance of braces, splints, standing frames, walkers, crutches, and corrective shoes purchased by MHCP may be authorized without team evaluation to maintain the team's recommendations.

4-004.04A Other Covered Services: MHCP may cover adaptive equipment. See 467 NAC 4-001.04.

4-004.05 Specific Providers: After the multi-disciplinary team has developed the IMTP, the client, parents, or guardian may choose the appropriate MHCP-contracted specialists to carry out the IMTP. MHCP-approved pharmacies and brace shops may be approved to provide other authorized services.

4-004.06 Procedures

4-004.06A Referrals: When a referral is received, the services coordinator must schedule the client for the next available clinic. If the client needs treatment before the next available clinic, the services coordinator must request Central Office approval for an interim evaluation.

The services coordinator must send a letter acknowledging the referral to the parents and to request the release of medical information. This letter should indicate the tentative appointment date.

When the signed release is received, the services coordinator must request medical reports from physicians and medical facilities involved in the client's CP treatment. Once all releases are obtained, the services coordinator must notify the client's primary care physician of the receipt of the referral and the MHCP clinic attendance appointments, if the primary care physician is listed on the release.

After the clinic report is completed, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is needed, the services coordinator must refer the case to MHCP Central Office staff for review.

4-004.06B Medical Eligibility Notification: If the client is medically eligible, the services coordinator must notify the client, parents, or guardian by letter and include a copy of the clinic report along with the financial application as appropriate.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision and send a copy of the clinic report, including the appeal paragraph in the letter. The services coordinator must enter the case action into the computerized system.

4-004.06C Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate manual reference and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-004.06C1 Private-Pay Patients at Clinics: Private-pay patients who are medically eligible for the cerebral palsy service program and under age 21 but financially ineligible may wish to continue to receive clinic evaluations or may request a clinic evaluation.

The family must pay $100 for the evaluation. The family must give the check or money order (no cash) to the services coordinator at least five working days before the clinic. The check must be made out to "Nebraska Health and Human Services." The services coordinator must send the check or money order to MHCP in the Central Office with an explanation of the purpose of the check.

4-004.06D Certification: When the client is financially and medically eligible, the services coordinator must certify the case and:

1. Contact the client, parents, or guardian if appropriate to obtain information necessary to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01A. Note: The follow-up interview should be completed before the certification letter is mailed whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send a letter to the physician notifying him/her of eligibility; and
5. Enter the case action into the computerized system.

4-004.06E Ongoing Services Coordination: The services coordinator must -

1. Authorize care as needed;
2. Schedule the client to return to the clinic as recommended at the last clinic evaluation (see 467-000-301);
3. Authorize maintenance care, e.g., brace repair, replacement shoes when necessary;
4. Schedule the client for the next available clinic if any care other than maintenance care, such as new braces, surgery, is needed (see 467-000-30);
5. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
6. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
7. Assist the family in dealing with the psychosocial aspects of the client's condition;
8. Request financial information update as needed, at least annually or when circumstances change; and
9. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01A (this may be completed as part of the clinic interview);
10. Continue to reassess need for other services; assist and refer as appropriate.

4-004.07 Cerebral Palsy Clinic Procedures

4-004.07A Clinic Purpose: MHCP sponsors cerebral palsy clinics to -

1. Determine medical eligibility for the cerebral palsy service; and
2. Develop a treatment plan for the client.

4-004.07B Scheduling: The MHCP services coordinator must send an appointment letter and "Referral Postcard," to the client, parents, or guardian to inform them of the schedule.

The MHCP services coordinator must review the case of each client scheduled to attend the clinic to determine any items (treatment plan, follow-up care, eligibility status) to be discussed with the team or the client, parents, or guardian. The services coordinator must print the computer screen for each client who is scheduled to attend the clinic.

4-004.07C Clinic Preparation: The services coordinator must -

1. Dictate clinic appointment letters for children to attend clinic using the appropriate letters, and send a stamped postcard or envelope with these letters. This postcard is used to inform the services coordinator of cancellation. It is helpful to put a date by which the postcard must be mailed (7-10 days in advance of clinic). If cards are not returned, it is assumed the child will attend.
2. Notify the Clinic lead services coordinator of any cancellations as soon as possible to allow the coordinator to direct other services coordinators to invite additional clients to the clinic.
3. Photocopy medical information (or the referral if no medical information is available) on new patients and pertinent medical information on ongoing clients, that is, ENT reports, school reports, letters of inquiry from the child's providers, surgical reports and provide this information at least one week before the clinic to the pediatrician and other team members as requested.

4-004.07D Team Responsibilities: See Quality Assurance document.

4-004.07E Services Coordinator Responsibilities: The MHCP services coordinator must meet with the client, parents, or guardian to discuss, as appropriate -

1. The purpose of the clinic and MHCP eligibility requirements (for new patients);
2. The client's treatment plan;
3. Follow-up care;
4. Any problems or concerns; and
5. Other resources which may cover needs of the client that MHCP cannot cover.

4-004.07E1: The services coordinator is a member of the clinic team during assessment and at the team meeting following the clinic. This includes -

1. Assisting the family to provide social information to team members;
2. Being familiar with the client's treatment plan and previous clinic recommendations;
3. Advocating for the client, parents, or guardian regarding any questions or concerns about the client's treatment;
4. Providing team members with information on the client's eligibility for MHCP;
5. Identifying concerns or problems regarding the client's treatment that the client, parents, or guardian may have and assisting them as appropriate when requested to do so by the family; and
6. Assisting the client, parents, or guardian in understanding the team's recommendations and assisting them in obtaining follow-up care and make referrals as appropriate.

4-004.07F Clinic Follow-Up: The services coordinator may need to take immediate action before the clinic reports are completed, based on decisions or questions raised by the team (such as, authorizing equipment or hospitalization).

After the services coordinator receives the reports, the services coordinator must send a follow-up letter to each client. The letter may -

1. Summarize for emphasis or clarity the recommendations made at the clinic as well as the client's current eligibility status, MHCP-covered services, and return clinic dates;
2. Give instructions for any care or procedures recommended by the clinic team but not covered by MHCP;
3. Discuss any questions or problems raised at the clinic; and
4. Make referrals to other sources when appropriate.

The clinic follow-up letter may be combined with a certification or rejection letter.

The services coordinator must update the computerized system, as appropriate.

The services coordinator must provide a summary of clinic results to all individuals who are determined not eligible for MHCP.

The services coordinator must assign new clinic appointment dates in computerized clinic system of names of any clients who are eligible and were recommended to return to another clinic for continued care.

4-005 through 4-009 (Reserved)

4-010 Craniofacial Service: This service provides treatment for children with craniofacial anomalies. Remains in chapter 3, section 005 as modified

4-010.01 Medical Eligibility: Medically eligible diagnoses include bilateral, unilateral, complete, and incomplete cleft lip and cleft palate. Remains in chapter 3, section 005.01 as modified

The MHCP medical consultant must review other craniofacial anomalies for a medical eligibility determination. Remains in chapter 3, section 005.01(A) but modified

4-010.02 Clinics/Diagnostic Evaluations: MHCP provides diagnostic evaluations at MHCP-sponsored craniofacial clinics. Remains in chapter 3, section 005.01 as modified

4-010.03 Certification Date: When the client is both medically and financially eligible, the certification date is the date of referral. The child must be scheduled for the earliest appropriate clinic.

4-010.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 005.02 as modified

1. Diagnostic clinic evaluations;
2. Surgical repair of cleft lip and cleft palate, tympanoplasty, tubes and other surgical procedures related to eligible conditions, for example, pharyngeal flap, nose/lip revisions). For other conditions, the services coordinator must send reports to the MHCP medical consultant for approval;
3. Orthodontic services for cleft palate (orthodontic treatment and routine dental care not associated with cleft palate are not covered;)
4. Routine dental care for cleft palate;
5. X-rays required for dental/orthodontic care and surgical procedures;
6. Pathology (lab);
7. Hearing aids, batteries, ear molds, repairs under $150, and three years of insurance premiums;
8. Physician services -
   a. Plastic surgeon; and
   b. Otolaryngologist;
9. Genetic consultation;
10. Nutrition;
11. Feeding and swallowing evaluation; and
12. Specialized feeding equipment and supplies relating to cleft lip and palate.

Note: MHCP requires pediatric pre-operative exams. These exams are always covered.

For service components not recommended in the IMTP, the services coordinator must submit requests for approval to MHCP Central Office staff, who determine coverage.

4-010.05 Specific Providers: The craniofacial clinic team consists of the family, a plastic surgeon, a speech pathologist, a pedodontist, an orthodontist, a prosthodontist, a pediatrician, clinic nurse coordinator, a nutritionist, audiologist, services coordinator, and a psychologist. The team may also include an otolaryngologist, an oral surgeon, and a dental hygienist.

MHCP-contracted plastic surgeons, otolaryngologists, dentists, orthodontists, recommended prosthodontists, audiologists, hearing aid dealers, pediatricians, nutritionists, and oral surgeons provide team recommended services.

4-010.06 Procedures

4-010.06A Referrals: When a referral is received, the services coordinator must schedule the client for the next available clinic. If the client needs treatment before the next available clinic, the services coordinator must request Central Office approval for an interim evaluation.

The services coordinator must send a letter acknowledging the referral to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. The services coordinator must send a letter acknowledging the referral to the referral source, if appropriate, indicating the date the client is scheduled for the clinic.

When the signed release is received, the services coordinator must request medical reports from physicians and medical facilities involved in the client's treatment. The multi-disciplinary team may review any medical reports at the clinic. The client may be scheduled for clinic even if this information is not available.

After the clinic report is completed, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is needed, the MHCP services coordinator must refer the case to MHCP Central Office staff who determine medical eligibility.

4-010.06B Referrals for Services Not Covered: Some referrals received by MHCP will not be approved for the craniofacial clinics. In such a situation, that is, purely orthodontic problems - malocclusion I without clefts) the services coordinator must consult with the Central Office for recommendations.

4-010.06C Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian by letter and include a copy of the clinic report, include a financial application as appropriate; and
2. Request a financial application.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision and send a copy of the clinic report, including the appeal paragraph in the letter. The services coordinator must enter the case action into the computerized system.

4-010.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and include the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-010.06D1 Private-Pay Patients at Clinics: Private-pay patients who are medically eligible for the craniofacial service and under age 21 but financially ineligible may wish to continue to receive clinic evaluations or may request a clinic evaluation.

The family must pay $100 for the evaluation. The family must give the check or money order (no cash) to the services coordinator at least five working days before the clinic. The check must be made out to "Nebraska Department of Health and Human Services." The services coordinator must send the check or money order to MHCP in the Central Office with an explanation of the purpose for the check.

4-010.06E Certification: When the client is financially and medically eligible, the services coordinator must certify the case and:

1. Contact the client, parents, or guardian if appropriate to obtain information necessary to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01A. Note: The follow-up interview should be completed before the certification letter is mailed whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send a letter to the physician notifying him/her of eligibility; and
5. Enter the case action into the computerized system.

4-010.06F Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the oral craniofacial condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-010.07 Craniofacial Clinic Procedures:

4-010.07A Clinic Purpose: MHCP sponsors clinics for the oral plastic service to -

1. Evaluate children with cleft lip, cleft palate, or any other cranio-facial anomalies;
2. Establish a diagnosis for medical eligibility determination;
3. Establish and monitor an individual medical treatment plan; and
4. Collect and report data on outcomes of treatment.

4-010.07B Scheduling Priorities: Priorities for craniofacial clinics are as follows:

1. Unrepaired cleft and lip;
2. New clients;
3. Ongoing clients due for evaluation for surgery;
4. Ongoing clients due for surgical follow-up;
5. Ongoing clients when the parents, school and/or medical/dental/orthodontic providers have requested input from the clinic team and/or a decision regarding the treatment plan; and
6. Ongoing clients due for regular clinic re-evaluation as recommended in the last IMTP.

Using these priorities, the services coordinator must assign the priority codes listed in the computer system.

4-010.07C Clinic Preparation: When scheduling children for clinics, the services coordinator must:

1. Review computer generated listings for children who are scheduled for any given clinic;
2. Prioritize those children to be scheduled and given clinic appointments;
3. Create a final list by computer for those who attend clinic, giving consideration for time and travel distances, evaluation needs, and a commitment from the family about their willingness to attend;
4. Contact individual families to verify medical status of previous recommendation, elicit the family's concerns, and get commitments of the families willingness and ability to attend;
5. Print and distribute clinic lists to team members as appropriate;
6. Send appointment notices to inform the families of the date, time, and place of the clinic, along with any appropriate instructions. This may include a return addressed post card in which the family can indicate whether or not they plan to keep the appointment;
7. Send the child's appointment notice to the primary care physician as appropriate to keep the physician informed and give the physician an opportunity to have his/her questions and/or concerns addressed by the evaluation team; and
8. Photocopy medical information (or the referral if no medical information is available) on new patients and pertinent medical information on ongoing clients, that is, ENT reports, school reports, letters of inquiry from the child's providers, surgical reports) and provide this information to the team as appropriate prior to the clinic.

4-010.07D Team Responsibilities: The individual team members must examine the client and as a team make recommendations for the IMTP.

4-010.07E Services Coordinator Responsibilities: The services coordinator must meet with each client and his/her parents or guardian. At this meeting, the services coordinator must -

1. Explain MHCP to all new clients;
2. Explain the clinic process and the client's eligibility status for MHCP;
3. Encourage the client, parents, or guardian to ask questions of the team members and explain what will occur as follow-up from the clinic evaluations;
4. Assess the family situation and with the families' permission make appropriate referrals to other appropriate services, including other MHCP services;
5. Review the care being received to identify problems or questions; and
6. Relay questions, concerns, and/or problems to the team members as well as eligibility information.

4-010.07F Clinic Follow-Up: The services coordinator may need to take immediate action before the clinic reports are completed, based on decisions or questions raised by the team (i.e., authorizing equipment or hospitalization).

After the services coordinator receives the reports, the services coordinator must send a report to each client and other providers as indicated by the parent/guardian. A follow-up clinic letter may be sent which may include eligibility information, questions, or answers raised at clinic; information about referrals and resources as appropriate.

The services coordinator must update the computerized system, as appropriate, which includes entering clinic appointment dates.

4-010.07G Scheduling Surgeries: The services coordinator, in coordination with the clinic nurse coordinator, must assist clients by keeping track of recommended surgeries and dates when these should be scheduled, that is, at least 6-8 weeks before surgery). Clients are directed to contact the office of the MHCP-contracted surgeon of their choice to request a surgery date and to schedule a pre-operative exam with an MHCP-contracted physician. Parents must notify the services coordinator of scheduled pre-operative appointment, hospital admission date, and surgery date. The services coordinator must send the appropriate authorizations. The services coordinator must send copies of the clinic report with surgical recommendations to the surgeon and the physician who will perform the pre-operative evaluation.

4-011 Cystic Fibrosis Service: This service provides treatment for cystic fibrosis. Remains in chapter 3, section 006 as modified

4-011.01 Medical Eligibility: The only eligible diagnosis is cystic fibrosis (fibrocystic disease). Cystic fibrosis is an inherited disease of exocrine glands, affecting most characteristically the pancreas, respiratory system, and sweat glands. Remains in chapter 3, section 006.01 as modified

4-011.02 Clinics/Diagnostic Evaluations: Only UNMC Cystic Fibrosis Center staff provide diagnostic and follow-up evaluations at designated area clinics. The services coordinator in conjunction with UNMC staff must arrange appointments for community-based clinics.

4-011.03 Certification Date: The certification date is the date of the referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 006.01(B) as modified

4-011.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 006.02 as modified

1. UNMC Cystic Fibrosis Center office evaluations;
2. Chest x-rays;
3. Laboratory tests, including throat cultures, sensitivity discs, urinalysis, and CBC with differential;
4. Approved medications, including, but not limited to -
   a. Pancreatic enzymes;
   b. Antibiotics for lung infections; and
   c. Bronchodilators;
5. Approved durable medical equipment -
   a. Purchase of compressors and nebulizers;
   b. Purchase of mechanical percussors;
   c. Rental of oxygen equipment; and
   d. Diabetic equipment including syringes;
6. Inpatient hospitalization at UNMC;
7. Treatment and evaluations with primary care physicians in consultation with the UNMC Cystic Fibrosis Center;
8. Treatment and evaluations related to secondary diagnoses resulting from cystic fibrosis, for example, diabetes, bowel obstructions; and
9. Nutrition services.

Note: The UNMC contract includes direct payment for respiratory therapist, nutritionist, or nurse clinician staff. MHCP will not pay for these services while the child is at UNMC.

The services coordinator must submit requests for approval of payments for service components not recommended in the IMTP to MHCP Central Office staff. MHCP Central Office staff must determine coverage.

4-011.04A Non-Covered Services: MHCP does not cover over-the-counter antihistamines, decongestants, and routine and/or acute health care, medication or routine health care unrelated to cystic fibrosis diagnosis.

4-011.05 Specific Providers: The UNMC Cystic Fibrosis Team is composed of a pediatric pulmonologist, a pediatric gastroenterologist, a nurse, a dietician, respiratory therapist, and lab technician (for sweat tests). When this team functions as the MHCP contracted Cystic Fibrosis Team, the family and services coordinator are part of the team makeup. The UNMC Hospital provides inpatient hospital care. MHCP-approved pharmacies provide prescribed medication. MHCP-approved durable medical equipment providers provide recommended equipment.

4-011.06 Procedures

4-011.06A Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and medical facilities involved in the client's cystic fibrosis care. Upon receipt of the medical reports, the services coordinator must follow the procedures in 467 NAC 4-011.06B and 4-011.06C.

4-011.06B Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parent(s), or guardian;
2. Request a financial application; and
3. Notify primary care physician.

If the client is not medically eligible, the services coordinator must notify the family of the decision. The services coordinator must enter the case action into the computerized system.

4-011.06C Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate manual reference and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-011.06D Certification: When the client is financially and medically eligible, the services coordinator must certify the case. The services coordinator must -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview as required by 467 NAC 2-002.01, unless completed at clinic. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact the providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send a letter to the primary care physician; and
5. Enter the case action into the computerized system.

4-011.06E Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to cystic fibrosis and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the client, parents, or guardian in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Assist the family in understanding the team's recommendations, assist in obtaining follow-up care, and make referrals as appropriate.

4-011.07 Cystic Fibrosis Clinic Procedures

4-011.07A Clinic Purpose: MHCP sponsors cystic fibrosis clinics to provide -

1. Diagnostic team evaluations; and
2. Team evaluations for certified patients to monitor progress, provide an IMTP, and give instructions to the patient for on-going care.

4-011.07B Scheduling: The services coordinator must -

1. Work in conjunction with the clinic coordinator to schedule children for evaluations;
2. Notify clients of scheduled appointments and may include authorization for lab and x-ray;
3. Review files of the clients scheduled for the clinic and print the computerized system screen for each client scheduled for this clinic.

MHCP Central Office staff must notify the hospital lab and x-ray departments regarding the clinic and indicate the number of clients scheduled, and notify the area physicians, hospitals of the clinic and staff attending the clinic.

4-011.07C Team Responsibilities: The cystic fibrosis team may be composed of the family, a pediatric pulmonologist, a pediatric gastroenterologist, a nurse-dietitian, a respiratory therapist, a social services coordinator, and a cystic fibrosis coordinator. The MHCP services coordinator may function as the social services coordinator on the team. The individual team members must examine the client and make recommendations regarding the client's treatment plan.

4-011.07D Services Coordinator Duties: The services coordinator may meet with each client, parents, or guardian to -

1. Explain the program to new patients;
2. Explain MHCP, the clinic evaluation process, and the client's MHCP eligibility status;
3. Encourage the client, parents, or guardian to ask questions of team members and explain what will occur as follow-up from the clinic evaluations;
4. Assess the family situation and make appropriate referrals to other community resources or for other MHCP services;
5. Review care being received to identify problems or questions;
6. Relay questions, concerns, and problems to the team members along with social and eligibility information; and
7. Interview the client, parent(s), and/or guardian as required in 467 NAC 4-011.06E.

4-011.07E Clinic Follow-Up: The services coordinator may need to take immediate follow-up action based on clinic recommendations before clinic reports have been completed, such as authorizing medication or authorizing and arranging hospitalization, etc. The services coordinator must update the computerized system as appropriate.

After the clinic reports are received, the services coordinator may send a clinic follow-up letter to the client, parents, or guardian to -

1. Summarize the clinic recommendations;
2. State the client's current eligibility status and return clinic date;
3. Specify what services are covered;
4. Address any questions or problems discussed at the clinic; and
5. Make referrals to other resources, if appropriate.

The clinic follow-up letter may be combined with the certification or rejection letter (see 467 NAC 4-011.06B).

The services coordinator maintains in the computer a tentative clinic list of the next clinic and add the names of any clients who are eligible and were recommended to return to the clinic for follow-up, using the MHCP computerized clinic system.

4-012 Diabetes Service: This service provides treatment for children who have diabetes mellitus. Remains in chapter 3, section 007 as modified

4-012.01 Medical Eligibility: The only eligible diagnosis is diabetes mellitus, Type I or Type II. Remains in chapter 3, section 007.01 as modified

Medical eligibility is determined by both the medical diagnosis and the IMTP. The medical consultant must review all cases for medical eligibility determination. Remains in chapter 3, section 007.01(A) but modified

4-012.02 Clinics/Diagnostic Evaluations: When determined appropriate by MHCP Central Office staff, the client must receive a diagnostic evaluation from a pediatric endocrinologist.

4-012.03 Certification Date: The certification date is the date of referral. Exception: For weekend or holiday, the referral must be received within five working days of the date of referral to cover eligibility. Remains in chapter 3, section 007.01(B) as modified

4-012.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 007.02 as modified

1. Diabetic specialist or pediatric office visits related directly to the diabetes;
2. Lab tests, including metabolic tests, urinalysis, and CBC with differentials;
3. Approved medications and insulin;
4. Syringes, needles, glucometers and other diabetic supplies;
5. Treatment and evaluations can be authorized with primary care physicians in consultation with the endocrinologist;
6. Inpatient hospitalizations; and
7. Nutrition services/diabetic counseling.

Note: MHCP Central Office staff must determine whether to purchase or rent infusion pumps.

4-012.05 Specific Providers: The MHCP contracted providers for this service is through a contracted endocrinologist or MHCP contracted pediatricians. The MHCP contracted Hospital provides inpatient hospital care. MHCP-approved pharmacies provide prescribed medication. MHCP-approved durable medical equipment providers provide recommended equipment.

4-012.06 Procedures

4-012.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and medical facilities involved in the diabetes care.

4-012.06B Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parent(s), or guardian;
2. Request a financial application; and
3. Notify primary care physician.

If the client is not medically eligible, the services coordinator must notify the family of the decision. The services coordinator must enter the case action into the computerized system.

4-012.06C Referrals From A Diabetes Team: When a referral is received from a diabetes team, the services coordinator must send the referral to the Central Office for medical eligibility determination. The services coordinator must also send a letter to the client, parents, or guardian, acknowledging the referral.

If the client is not medically eligible, the services coordinator must notify the family of the decision. The services coordinator must enter the case action into the computerized system.

4-012.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-012.06E Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the parents or guardian to explain the service, obtain necessary information to authorize care, and arrange a follow-up interview as required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the family. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and

e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);

4. Send letter to the physician in charge of care; and
5. Enter the case action into the computerized system.

4-012.06F Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to diabetes and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the client, parents, or guardian in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01;
8. Continue to reassess need for other services; assist and refer as appropriate.

4-013 Eye Service: This service provides treatment for children who have eye defects which may be surgically corrected. Remains in chapter 3, section 008 as modified

4-013.01 Medical Eligibility: The most common diagnoses covered are ptosis, exotropia, esotropia, congenital cataracts, glaucoma, and blocked tear ducts. Medical eligibility for this service is dependent upon the need for surgery. Remains in chapter 3, section 008.01 as modified

4-013.02 Clinics/Diagnostic Evaluations: All appointments must be scheduled with MHCP-contracted ophthalmologists. There are no MHCP-sponsored clinics for eye services.

4-013.03 Certification Date: The certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 008.01(B) as modified

4-013.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 008.02 as modified

1. Diagnostic eye evaluations, only when referred by a medical professional or para-professional;
2. Office visits with contracted ophthalmologists; and
3. Surgery and hospitalization for correction of an eye defect when prior authorization has been received.

If any other service components are recommended in the IMTP, the services coordinator must submit reports to the medical consultant. The services coordinator must submit requests for approval of service components not recommended in the IMTP to MHCP Central Office staff. MHCP Central Office staff must determine coverage.

Note: MHCP may cover only the first pair of eye glasses or contact lenses provided after each surgery. The services coordinator must submit requests for eye glasses or contact lenses to MHCP Central office staff.

4-013.05 Specific Providers: Services are provided through MHCP-contracted ophthalmologists and MHCP-contracted hospitals. MHCP-approved optometrists may provide eyeglasses or contact lenses.

4-013.06 Procedures

4-013.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and request the release of medical information. A copy of the acknowledgement letter may be sent to the referring party.

When the signed release is received, the services coordinator must request relevant medical reports from physicians and/or medical facilities involved in the client's eye care. Upon receipt of the medical reports, the services coordinator must follow the procedures in 467 NAC 4-013.06B and 4-013.06C.

4-013.06B Referrals From General Physicians or Pediatricians: If the referral is not from a contracted ophthalmologist but the client has been seen by a contracted ophthalmologist, the services coordinator must request release of medical information from the client to obtain relevant reports and treatment plan. When the IMTP is received, the services coordinator must verify medical eligibility. If further medical review is necessary, the services coordinator must submit the report to the Central Office.

If the referral is from another source, the services coordinator or the family must schedule the client for a diagnostic evaluation with a contracted ophthalmologist. After the report is received, the services coordinator must verify medical eligibility. If further medical review is necessary, the services coordinator must submit the report to the Central Office.

4-013.06C Referrals from Contracted Specialists: If the referral is from a contracted ophthalmologist and the client has an eligible diagnosis and surgery has been recommended, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is needed, the services coordinator must refer the case to MHCP Central Office staff. MHCP Central Office staff must determine medical eligibility and return reports to the services coordinator with eligibility coding.

4-013.06D Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian; and
2. Request a financial application.

If the client is not medically eligible, the services coordinator must notify the family of the decision. The services coordinator must enter the case action into the computerized system.

4-013.06E Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client's parents of the determination by letter, citing the appropriate manual reference and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-013.06F Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview as required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Make sure MHCP Clinic reports are sent to the primary care physician; and
5. Enter the case action into the computerized system.

4-013.06G Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to eye care and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-014 Hearing Service: This service provides treatment for children who have a significant hearing loss requiring amplification or have a condition which may result in a hearing loss. The purpose of these services is to improve hearing acuity and/or to prevent further loss of hearing. Remains in chapter 3, section 009 as modified

4-014.01 Medical Eligibility: The Medically Handicapped Children's Program may fill service gaps for infants needing additional diagnostic, medical treatment planning, and medical treatment services beyond the newborn hearing screening phase, subject to the local school system's responsibilities. Remains in chapter 3, section 009.01 as modified

Eligibility for hearing services must be evidenced by a permanent hearing loss or a medical condition resulting in a permanent hearing loss. MHCP Central Office staff must review each case. Last sentence is modified and remains in chapter 3, section 009.01(A).

Medical conditions which include a hearing loss but respond to medication and placement of tubes (myringotomy) and usually result in normal hearing are considered acute conditions and are not medically eligible.

4-014.02 Diagnostic Evaluations: MHCP Central Office staff must review reports from the following practitioners to determine medical eligibility:

1. An MHCP-contracted physician specializing in diseases and conditions of the ear, nose, and throat (ENT/otolaryngologist);
2. An audiologist; and
3. A pediatric/family physician report or evaluation, if required by MHCP Central Office staff to establish eligibility.

MHCP pays for these evaluations when provided by MHCP-contracted specialists after referral by a medical professional or para-professional.

4-014.03 Certification Date: The certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 009.01(B) as modified

4-014.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 009.02 as modified

1. Diagnostic evaluations and ongoing care with ear, nose, and throat specialists;
2. Diagnostic and ongoing services with contracted audiologists;
3. Hearing aids, ear molds, and repairs;
4. Hospitalizations;
5. An evaluation by an MHCP-contracted pediatrician if surgery or a hearing aid is recommended; and
6. Insurance for loss and destruction of aid purchased by MHCP.

If any other service components are recommended in the IMTP, the services coordinator must submit the reports to the medical consultant for approval of payment.

4-014.05 Specific Providers: Care is provided by MHCP-contracted physicians specializing in diseases of the ear, nose, and throat (ENT/otolaryngologists), MHCP-contracted audiologists, and MHCP-contracted hearing aid dealers.

4-014.06 Procedures

4-014.06A Referrals From Audiologists or Para-Professionals: When a referral from an audiologist or other para-professional is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

If the referral is generated by a failed newborn screening, the services coordinator must request a report of the second hearing screening. If the child has failed the second screening, the services coordinator contacts Early Development Network in the child's community to access school services by contacting the Local Early Development Network services coordinator. The reports must then be sent to Central Office staff for review.

When the signed release is received, the services coordinator must request the audiologist's report and information from medical facilities involved in the client's hearing care. Upon receipt of the medical reports, the services coordinator must follow the procedures in 467 NAC 4-014.06B and 4-014.06C.

4-014.06B Referrals From General Physicians or Pediatricians: When a referral from a family physician or pediatrician is received, the services coordinator must acknowledge receipt of the referral by sending the acknowledgement letter to the client, parents, or guardian. The services coordinator, with the client, parents, or guardian, must arrange an otolaryngology evaluation. The services coordinator must send an authorization if needed, to the provider and request a medical report. If an audiologist has not evaluated the client, the services coordinator, with the client, parents, or guardian, must arrange for an audiology evaluation. The services coordinator must send an authorization requesting an audiogram.

The services coordinator must send the results of the evaluation to the Central Office. MHCP Central Office staff must determine medical eligibility and return to the services coordinator with eligibility coding.

4-014.06C Referrals From Otolaryngologists: The services coordinator must submit referrals from specialists to the Central Office for review.

4-014.06D Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian; and
2. Request a financial application.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-014.06E Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate manual reference and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-014.06F Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the family. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send letter to the contracted provider; and
5. Enter the case action into the computerized system.

4-014.06G Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the hearing condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;

4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change; and
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-015 Heart Service: This service covers treatment for children with congenital or acquired heart disease. Remains in chapter 3, section 010 as modified

4-015.01 Medical Eligibility: Common diagnoses which are covered by this service are – Remains in chapter 3, section 010.01 as modified

1. Tetralogy of Fallot;
2. Transposition of the great vessels;
3. Coarctation of the aorta;
4. Mitral/aortic valve stenosis;
5. Ventricular septal defect (VSD); and
6. Atrial septal defect (ASD).

The MHCP medical consultant must review all other diagnoses. Remains in chapter 3, section 010.01(A) as modified

4-015.02 Clinics/Diagnostic Evaluations: Diagnostic evaluations are provided through contracted pediatric cardiologists.

4-015.03 Certification Date: When the client is both medically and financially eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 010.01(B) as modified

4-015.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 010.02 as modified

1. Diagnostic evaluations, including chest x-rays, echocardiograms, electrocardiograms, stress tests, treadmill, Holter monitors, etc.;
2. Physician services by -
   a. A pediatric cardiologist;
   b. A pediatrician, for follow-up care such as blood level tests under the supervision of the cardiologist; and
   c. A pediatric thoracic surgeon;
3. Hospitalization for heart surgery, cardiac catheterizations, and pacemakers evaluations;
4. X-rays;
5. Central Office-approved heart medications;
6. Pathology; and
7. Nutrition services.

The services coordinator must submit requests for approval of service components not recommended in the IMTP to MHCP Central Office staff.

4-015.05 Specific Providers: MHCP covers heart services provided by an MHCP-contracted pediatric cardiologist, pediatrician, or pediatric thoracic surgeon. These services may be provided at the UNMC Pediatric Cardiology Clinic, MHCP-sponsored clinics, an MHCP-contracted pediatric cardiologist's office, or MHCP-contracted hospitals.

MHCP covers hospitalization for open-heart surgery only at UNMC Hospital and Children's Memorial Hospital in Omaha, Nebraska.

Pharmacy services, radiology and pathology services, and durable medical equipment may be provided by MHCP-approved providers.

Any exceptions in providers must be reviewed by the medical consultant.

4-015.06 Procedures

4-015.06A Non-Medical Referrals: When the services coordinator receives a referral that has no medical information, the services coordinator must arrange a diagnostic evaluation at the first available heart clinic. The services coordinator must notify the client, parents, or guardian regarding the appointment. After receipt of the report of diagnostic evaluation, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is needed, the services coordinator must send the report to the medical consultant for a medical eligibility determination.

4-015.06B Referrals From General Physicians or Pediatricians: When the services coordinator receives a referral from a general physician or pediatrician, the services coordinator must schedule a diagnostic evaluation for the child and notify the client, parents, or guardian and the referring physician. After receipt of the report of diagnostic evaluation, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is needed, the services coordinator must send the report to the medical consultant for a medical eligibility determination.

4-015.06C Referrals From Pediatric Cardiologists: When the services coordinator receives a referral from an MHCP-contracted pediatric cardiologist, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If review is necessary, the services coordinator must send the referral to the MHCP medical consultant.

4-015.06D Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian;
2. Request a financial application;
3. Notify the referring physician regarding eligibility.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-015.06E Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-015.06F Certification: When the client is financially and medically eligible, the services coordinator must certify the case. The services coordinator must -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01, unless done at clinic. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible.
2. Contact providers including primary care physician to explain MHCP and billing procedures;
3. Send a certification letter to the family. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. The procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Enter the case action into the computerized system.

4-015.06G Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the eligible heart condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep the medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Assist the family in understanding the team’s recommendations, assist in obtaining follow-up care, and make referrals as appropriate.

4-015.07 Heart Clinic Procedures:

4-015.07A Purpose of Heart Clinics: MHCP sponsors heart clinics to -

1. Locate and provide diagnostic evaluations for children with heart disease or conditions leading to heart disease;
2. Ensure high-quality specialized heart care for those children;
3. Ensure continuity of care for those children; and
4. Develop and monitor an IMTP for each child.

MHCP sponsors heart clinics throughout Nebraska to bring high-quality specialized services to those patients who live great distances from the pediatric cardiac centers.

4-015.07B Scheduling for Ongoing Clinics in Omaha and Lincoln: All appointments are scheduled by request to the appropriate cardiologist offices.

4-015.07C Services Coordinator Responsibilities: The services coordinator must attend clinic when new patients are scheduled to interview parents, to explain MHCP policies and services, and to obtain a signed Exchange of Information Form. The services coordinator must interview the client, parent(s), and/or guardian as required in 467 NAC 4-015.06G, item 7.

4-015.07D Clinic Follow-Up: The services coordinator contacts the cardiology department to verify the child's attendance within three days of the appointment date. The services coordinator must update the computerized system, as appropriate. The UNMC pediatric cardiology department sends a copy of each client's report to the services coordinator. If the report is not received within one month of the appointment date, the services coordinator must request the report.

4-016 Hemophilia Service: This service provides treatment for hemophilia. Remains in chapter 3, section 011 as modified

4-016.01 Medical Eligibility: Hemophilia is a genetically transmitted disease caused by deficiency of an antihemophilic globulin (Factor VIII). Bleeding episodes may occur due to minor injuries, surgeries, dental work, etc., and may require extensive treatment. Medically eligible diagnoses are congenital factor VIII and severe factor IX disorders, such as hemophilia and Christmas disease. Remains in chapter 3, section 011.01 as modified

4-016.02 Clinics/Diagnostic Evaluations: There are no MHCP-sponsored clinics for hemophilia. Diagnostic evaluations are provided through the regional hemophilia centers and by contracted hematologists.

4-016.03 Certification Date: When the client is both medically and financially eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 011.01(B) as modified

4-016.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 011.02 as modified

1. Inpatient hospital care;
2. Outpatient evaluations at a regional hemophilia center or by an MHCP-contracted hematologist;
3. Laboratory services;
4. X-rays;
5. Factor VIII;
6. Supplies for Factor VIII administration, such as syringes, needles, etc.; and
7. Nutrition services.

Service components may be limited based on budget consideration.

If any other service components are recommended in the IMTP, the services coordinator must submit medical reports to the medical consultant for approval of payment. The services coordinator must submit requests for approval of service components not recommended in the IMTP to MHCP Central Office staff to determine coverage.

4-016.05 Specific Providers: Covered services must be provided by regional hemophilia centers at UNMC in Omaha and at the University of Colorado Medical Center in Denver, MHCP-contracted hematologists, UNMC, and MHCP-contracted orthopedists. Local providers may be approved if they are under the direct supervision of the MHCP-contracted hematologist or regional hemophilia center.

4-016.06 Procedures

4-016.06A Non-Medical Referrals: When the services coordinator receives a non-medical referral and the diagnosis has not been confirmed, the services coordinator must arrange a diagnostic evaluation with an MHCP-contracted provider. The services coordinator must send a letter to the client, parents, or guardian with the appointment information and to request the release of medical information. MHCP pays for the diagnostic evaluation.

If the diagnosis has been confirmed, the services coordinator requests medical reports from physicians and/or medical facilities. Upon receipt of the medical reports, the services coordinator must follow the procedures in 467 NAC 4-016.06B and 4-016.06C.

4-016.06B Referrals From General Physicians or Pediatricians: For medical referrals not from MHCP-contracted hematologists, the services coordinator must arrange a diagnostic evaluation with a contracted provider. The services coordinator must verify medical eligibility or, if further review is needed, the services coordinator must send the referral to the MHCP medical consultant (see 467 NAC 2-003 ff.). The services coordinator must also discuss a change of providers with the client, parents, or guardian if appropriate.

4-016.06C Referrals From Hematologists: If a medical referral is received from a provider contracted with MHCP for hemophilia treatment or a regional hemophilia center, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If additional review is needed, the services coordinator must send the referral with medical eligibility determination inquiry to the MHCP medical consultant for medical eligibility determination.

4-016.06D Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian; and
2. Request a financial application.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-016.06E Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate manual reference and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system and authorize payment for any covered diagnostic evaluations and send it to the Central Office.

4-016.06F Certification: When the client is financially and medically eligible, the services coordinator must certify the case. The services coordinator must -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Send appropriate authorization and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send a letter to the physician in charge of care notifying of eligibility; and
5. Enter the case action into the computerized system.

4-016.06G Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to hemophilia and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in referrals for the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change; and
7. Continue to reassess need for other services; assist and refer as appropriate.

4-017 Major Medical-General Service: This service provides treatment for children with diagnoses determined to be congenital, chronic, or prolonged, and in need of active treatment. If a child's diagnosis does not meet the criteria for other MHCP services, s/he may be considered for this service. Remains in chapter 3, section 012 as modified

4-017.01 Medical Eligibility: Some common diagnoses covered by this service include Addison's disease, Turner's syndrome, hypothyroidism, esophageal strictures, imperforate anus, tracheoesophageal fistula, choanal atresia, enterocolitis, Hirschprung's disease, aplastic anemia, gastroschisis, growth hormone deficiency, PKU (phenylketonuria), and duodenal atresia.

Medically eligible immunological deficiencies are congenital hypogammaglobulinemia, acquired hypogammaglobulinemia, DiGeorge's syndrome, severe combined immunodeficiency, ataxia-telangiectasia syndrome, Wiskott-Aldrich syndrome, chronic grenulomatous disease, Chediak-Higashi syndrome, and Kostman's syndrome. Complement deficiencies must be reviewed by the medical consultant.

MHCP does not cover growth hormone transplants of bone marrow and thymus or the following immunological deficiencies: selective Ig A deficiency, chronic mucocutaneous candidiasis, hyper Ig E syndrome, and Hill-Quie syndrome. Remains in chapter 3, section 012.01 as modified

The medical consultant must review all referrals for medical eligibility determination. Remains in chapter 3, section 012.01(A) as modified

4-017.02 Clinics/Diagnostic Evaluations: There are no MHCP-sponsored clinics for this service. Further diagnostic evaluations may be covered if determined to be necessary by the MHCP medical consultant. The medical consultant must also review the treatment plan.

4-017.03 Certification Date: When the child is both medically and financially eligible, the certification date is the date of the referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 012.01(B) as modified

4-017.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 012.02 as modified

1. Diagnostic evaluations;
2. Consultations;
3. Hospitalizations;
4. Surgery;
5. X-rays and pathology;
6. Physician services;
7. Approved medications;
8. Medical supplies or equipment and its maintenance; and
9. Nutrition services.

If any other service components are recommended in the IMTP, the services coordinator must submit the report to the medical consultant for approval of payment. The services coordinator must submit requests for approval of payment for service components not recommended in the IMTP to MHCP Central Office staff. MHCP Central Office staff must determine coverage.

4-017.05 Specific Providers: Covered services are provided by MHCP-contracted physicians and hospitals. MHCP Central Office staff must approve other providers.

4-017.06 Procedures

4-017.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and/or medical facilities involved in the client's medical care. The services coordinator must send the reports to the medical consultant for a medical eligibility determination. MHCP Central Office staff must determine medical eligibility and return the reports to the services coordinator with eligibility coding.

4-017.06B Medical Eligibility Notification: After the services coordinator receives the coded report, if the child is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian; and
2. Include a financial application in the letter.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-017.06C Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-017.06D Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parent(s) or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;

2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the family. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send a letter to the physician in charge of care; and
5. Enter the case action into the computerized system.

4-017.06E Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to covered diagnosis and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01;
8. Continue to reassess need for other services; assist and refer as appropriate.

4-018 Midline Neurological Defects Service: This centralized service provides treatment for children with spina bifida, meningomyelocele, or other central nervous system neurological defects. Remains in chapter 3, section 013 as modified

4-018.01 Medical Eligibility: Some common covered diagnoses include spina bifida aperta with hydrocephalus, spina bifida aperta without hydrocephalus, spina bifida occulta, congenital hydrocephalus, encephalocele, obstructive hydrocephalus (acquired), hydranencephaly, spinal cord lesion, and craniosynostosis requiring surgery. Remains in chapter 3, section 013.01 as modified

If the client has a definite diagnosis of spina bifida or meningomyelocele, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If the client has any other diagnosis, the medical consultant must determine medical eligibility. Remains in chapter 3, section 013.01(A) as modified

4-018.02 Clinics/Diagnostic Evaluations: MHCP sponsors midline neurological team clinics in Lincoln and Omaha. Treatment is supervised by the clinic team and is provided by contracted specialists.

4-018.03 Certification Date: When the client is medically and financially eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 013.01(B) as modified

4-018.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 013.02 as modified

1. X-rays;
2. Laboratory tests;
3. CT scans, renal scans and MRI;
4. Braces and splints and their maintenance;
5. Standing frames, walkers, and crutches and their maintenance;
6. Hospitalizations approved by the medical consultant;
7. Ostomy supplies;
8. Physicians' services provided by a developmental pediatrician, neurosurgeon, urologist, orthopedist, neurologist, or primary care physician as related to the condition;
9. Surgery related to the condition;
10. Emergency shunt revisions;
11. Medications;
12. Nutrition services; and
13. Feeding and swallowing evaluations.

If any other service components are recommended in the IMTP, the services coordinator must submit reports to the medical consultant for approval of payment. The services coordinator must submit requests for approval of payment for service components not recommended in the IMTP to MHCP Central Office. MHCP Central Office staff must determine coverage.

4-018.04A Other Covered Services: MHCP, through the midline neurological services, may cover certain adaptive equipment, such as wheelchairs, van lifts, or equipment for home use.

4-018.05 Specific Providers: Covered services must be provided by MHCP-contracted physicians, MHCP-contracted hospitals, and MHCP-approved brace companies with certified orthotists, and pharmacies.

4-018.06 Procedures

4-018.06A Referrals on Neonates or Others Needing Immediate Medical Attention: When the services coordinator receives a referral on a neonate (a newborn infant during the initial hospitalization for birth) or a child needing immediate medical attention, s/he must send a letter to the child, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and/or medical facilities involved in the client's medical care. Upon receipt of the medical reports, the services coordinator must submit the reports to the MHCP medical consultant for medical eligibility determination. MHCP Central Office staff must determine medical eligibility and return to the services coordinator with eligibility coding. The worker must schedule the child for a clinic evaluation as soon as appropriate.

4-018.06B Referrals on Other Children: When the services coordinator receives a referral on a client who has been dismissed from initial hospitalization for birth and who does not need immediate medical attention, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral, to explain that the client may be seen in an MHCP-sponsored clinic, and to request the release of medical information. A copy of the letter may be sent to the referring party. The services coordinator must tentatively schedule the client for an appropriate clinic. The services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is necessary, the services coordinator must submit the IMTP to the Central Office for review. After review, MHCP Central Office staff must determine medical eligibility and return the medical report to the services coordinator with eligibility coding.

4-018.06C Medical Eligibility Notification: After medical eligibility is established, the services coordinator must -

1. Notify the client, parents, or guardian;
2. Request a financial application; and
3. Notify primary care physician.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-018.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate manual reference and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-018.06D1 Private-Pay Patients at Clinics: Private pay patients who are medically eligible for the midline neurological service and under age 21 but financially ineligible may wish to continue to receive clinic evaluations or may request a clinic evaluation.

The parents or guardian are required to pay $100 for the evaluation. The parents or guardian must give the check or money order (no cash) to the services coordinator at least five working days before the clinic. The check must be made out to "Nebraska Department of Health and Human Services." The services coordinator must send the check or money order to MHCP Central Office staff with an explanation.

4-018.06E Certification: When the client is financially and medically eligible, the services coordinator must:

1. Certify the case;
2. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and to arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
3. Contact providers to explain MHCP and billing procedures;
4. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
5. Notify the primary care physician; and
6. Enter the case action into the computerized system.

4-018.06F Coordination of Care: The services coordinator must assist the client, parents, or guardian in arranging follow-up care as recommended by the team, encouraging the client, parents, or guardian to make the appointments.

4-018.06G Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the MHCP-eligible diagnosis and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-018.07 Clinic Procedures

4-018.07A Clinic Purpose: MHCP sponsors clinics for the midline neurological defects service to -

1. Assess the client's neurologic, neurosurgical, orthopedic, and urologic needs; and
2. Establish a treatment plan for the client's needs.

4-018.07B Scheduling: The MHCP services coordinator must send an appointment letter and return postcard to the client, parents, or guardian to inform them of the scheduled appointment.

The MHCP services coordinator may need to review the case of each client scheduled to attend the clinic to determine any items (treatment plan, follow-up care, eligibility status) to be discussed with the team or the client, parents, or guardian. The services coordinator must print the computerized system screen for each client.

4-018.07C Team Responsibilities: The clinic team may include a pediatrician, a neurosurgeon, a orthopedist, a physical therapist, a urologist, parents, an occupational therapist, a nutritionist, a nurse coordinator, a social services coordinator, and a psychologist. The MHCP team members must examine the client and make recommendations regarding the client's treatment plan.

4-018.07D Services Coordinator Responsibilities: The MHCP services coordinator must meet with the client, parents, or guardian to discuss -

1. The purpose of the clinic and MHCP eligibility requirements (for new patients);
2. The client's treatment plan;
3. Follow-up care;
4. Any problems or concerns;
5. MHCP eligibility; and
6. Other resources which may cover needs of the client that MHCP cannot cover.

The services coordinator must interview the client, parent(s), or guardian as required.

4-018.07D1: The services coordinator is a member of the clinic team during assessment and at the staff meeting following the clinic. This includes -

1. Providing family issues to team members as appropriate;
2. Being familiar with the client's treatment plan and previous clinic recommendations;
3. Advocating for the client, parents, or guardian regarding any questions or concerns about the client's treatment;
4. Providing team members with information on the client's eligibility for MHCP;
5. Identifying concerns or problems regarding the client's treatment that the client, parents, or guardian may have and assisting them as appropriate; and
6. Assisting the client, parents, or guardian in understanding the team's recommendations and assisting them in obtaining follow-up care.

4-018.07E Clinic Follow-Up: The services coordinator may need to take immediate follow-up action based on clinic recommendations before clinic reports have been completed, such as authorizing medication or authorizing and arranging hospitalization, etc. The services coordinator must update the computerized system as appropriate.

After the clinic reports are received, the services coordinator may send a clinic follow-up letter and/or clinic report to the client, parents or guardian to –

1. Summarize the clinic recommendations;
2. State the client’s current eligibility status and return clinic date;
3. Specify what services are covered;
4. Address any questions or problems discussed at the clinic; and
5. Make referrals to other resources, if appropriate.

The clinic follow-up letter may be combined with the certification or rejection letter (see 467 NAC 4-018.06D and 4-018.06E).

The services coordinator maintains in the computer a tentative clinic list of the next clinic and adds the names of any clients who are eligible and were recommended to return to the clinic for follow-up, using the MHCP computerized system.

4-019 Neoplasm Service: This service provides treatment for children with neoplastic (cancerous) diseases or non-malignant tumors when the tumor is potentially disabling. Remains in chapter 3, section 014 as modified

4-019.01 Medical Eligibility: The most common covered diagnoses are leukemia, lymphoma, Ewing's sarcoma, Wilm's tumor, rhabdomyosarcoma, neuroblastoma, astrocytoma, osteogenic sarcoma, and some brain tumors. Remains in chapter 3, section 014.01 as modified

The services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is needed, the medical consultant must review the referral for a medical eligibility determination. Remains in chapter 3, section 014.01(A) as modified

4-019.02 Clinics/Diagnostic Evaluations: There are no MHCP clinics for this service. The diagnosis must be determined by an MHCP-contracted oncologist or hematologist.

4-019.03 Certification Date: When the client is both financially and medically eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 014.01(B) as modified

4-019.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 014.02 as modified

1. Chemotherapy, radiation (inpatient and outpatient);
2. Surgery for treatment of cancer;
3. Hospitalizations;
4. Medications (only for treatment of cancer) and supplies;
5. Laboratory and radiology services;
6. Treatments provided by MHCP-contracted oncologists or hematologists;
7. Follow-up care, provided by the local physician under supervision of the contracted oncologist or hematologist; and
8. Prosthetic devices;
9. Emergency care; and
10. Nutrition services.

If any other service components are recommended in the IMTP, the services coordinator must submit the report to the medical consultant for approval of payment. The services coordinator must submit requests for approval of payment for service components not recommended in the IMTP to MHCP Central Office staff. MHCP Central Office staff must determine coverage.

4-019.05 Specific Providers: Covered services must be provided through contracted oncologists, hematologists and hospitals. Other MHCP-contracted specialists may provide services as recommended by the oncologist and approved by MHCP Central Office staff. MHCP-approved pharmacies may provide medications and supplies.

4-019.06 Procedures

4-019.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and/or medical facilities involved in the client's treatment.

4-019.06B Medical Referrals From Specialists: If the referral is from an MHCP-contracted oncologist or hematologist, the services coordinator must verify medical eligibility (see 467 NAC 2-003 ff.). If further review is needed, the services coordinator must send the referral to the MHCP medical consultant for medical eligibility determination. MHCP Central Office staff must determine medical eligibility and return the report to the services coordinator with eligibility coding.

4-019.06C Medical Eligibility Notification: After the services coordinator verifies medical eligibility or receives the coded report and if the client is medically eligible the services coordinator must -

1. Notify the client, parents or guardian; and
2. Request that they complete the financial application included in the letter.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision by letter. The services coordinator must enter the case action into the computerized system.

4-019.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-019.06E Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -

a. The service for which the client is certified;
b. The certification date;
c. Medical care eligible for payment;
d. Authorized providers; and
e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);

4. Notify the physician in charge of care; and
5. Enter the case action into the computerized system.

4-019.06F Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the eligible diagnosis and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-020 Major Medical-Neurological Service: This service provides treatment for neurological conditions. Remain in chapter 3, section 015 as modified

4-020.01 Medical Eligibility: Eligible diagnoses include seizures, subdural hematoma, encephalocele, and Guillian-Barre syndrome. The MHCP medical consultant must determine medical eligibility from medical reports.

MHCP does not cover seizures occurring during the newborn's initial hospitalization at birth. Remains in chapter 3, sections 015.01 and 015.01(A) as modified

4-020.02 Clinics/Diagnostic Evaluations: MHCP covers diagnostic evaluations performed by a pediatric neurologist. There are no MHCP-sponsored clinics for this service.

4-020.03 Certification Date: When the client is both medically and financially eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 015.01(B) as modified

4-020.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 015.02 as modified

1. Diagnostic evaluations;
2. Consultations;
3. X-rays;
4. Pathology;
5. Pediatric neurologist services;
6. Treatment drugs;
7. EEG's, CT scans or MRI, recommended by the pediatric neurologist;
8. Hospitalizations; and
9. Nutrition services.

If any other service components are recommended in the IMTP, the services coordinator must submit the medical report to the MHCP medical consultant for approval of payment. The services coordinator must submit requests for approval of payment for service components not recommended in the IMTP to MHCP Central Office staff. MHCP Central Office staff must determine coverage.

4-020.05 Specific Providers: Covered services must be provided by MHCP-contracted pediatric neurologists and hospitals. Local pediatricians may provide care under the supervision of the neurologist with MHCP Central Office approval. MHCP-approved pharmacies may provide approved medications.

4-020.06 Procedures

4-020.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and/or medical facilities involved in the client's medical care. The services coordinator must send the reports to the medical consultant for a medical eligibility determination. MHCP Central Office staff must determine medical eligibility and return the reports to the services coordinator with eligibility coding.

4-020.06B Referrals From Physicians: The services coordinator must submit the medical referral to the Central Office for review. After review, MHCP Central Office staff must determine medical eligibility and return the report to the services coordinator with eligibility coding.

4-020.06C Medical Eligibility Notification: After the services coordinator receives the report, if the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian by letter; and
2. Include a financial application.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-020.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-020.06E Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;

c. Medical care eligible for payment;
d. Authorized providers; and
e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);

4. Notify the pediatric neurologist; and
5. Enter the case action into the computerized system.

4-020.06F Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the client's neurological condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate..

4-021 Orthopedic - General Service: This service covers treatment of general orthopedic problems, congenital or acquired, excluding recent fractures. Remains in chapter 3, section 016 as modified

4-021.01 Medical Eligibility: The most common covered diagnoses are talipes equinovarus, arthrogryposis, Legg-Perthes disease, congenital dislocation of the hip, and children needing prostheses.

The MHCP medical consultant must review a spinal cord injury. MHCP does not cover the initial acute treatment but may cover rehabilitation care. Other diagnoses that must be reviewed by the medical consultant are tibial torsion, "bowed legs", torn medial meniscus, leg length discrepancy, and fractures that have not healed properly. Remains in chapter 3, sections 016.01 and 016.01(A) as modified

4-021.02 Clinics/Diagnostic Evaluation: Diagnostic evaluations are provided through MHCP-contracted orthopedists.

4-021.03 Certification Date: When the client is both medically and financially eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 016.01(B) as modified

4-021.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 016.02 as modified

1. Orthopedic visits;
2. Multidisciplinary Team evaluations (i.e., CP Clinics);
3. X-rays;
4. Orthotic appliances (including walkers, splints, crutches, and prostheses);
5. Brace repairs;
6. Inpatient and outpatient orthopedic surgery; and
7. Nutrition services.

For service components not recommended in the IMTP, the services coordinator must submit requests for approval to MHCP Central Office staff.

4-021.04A Other Covered Services: MHCP may cover adaptive equipment, such as wheelchairs, van lifts, equipment for home use, or standing tables. See 467 NAC 4-001.04.

4-021.05 Specific Providers: Hospitalizations must be in MHCP-contracted facilities and are covered only when recommended by MHCP-contracted orthopedists. Braces and repairs must be provided only by MHCP-approved companies employing certified or MHCP-approved orthotists.

4-021.06 Procedures

4-021.06A Non-Medical Referrals and Referrals From General Physicians or Pediatricians: If the referral is not from a contracted orthopedist but the client has been seen by a contracted orthopedist, the services coordinator must request the release of information from the client to obtain relevant reports and treatment plan. When the IMTP is received, the services coordinator must verify medical eligibility. If further medical review is necessary, the services coordinator must submit the report to the Central Office.

If the referral is from another source, the services coordinator or the family must schedule the client for a diagnostic evaluation with a contracted orthopedist. After the report is received, the services coordinator must verify medical eligibility. If further medical review is necessary, the services coordinator must submit the report to the Central Office.

4-021.06B Referrals from Orthopedists: If the services coordinator receives a referral from a contracted orthopedist, the services coordinator must verify medical eligibility. If further review is needed, the services coordinator must send the referral to the MHCP medical consultant for medical eligibility determination.

4-021.06C Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian; and
2. Request a financial application.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-021.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate manual reference and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-021.06E Certification: When the client is financially and medically eligible, the services coordinator must certify the case. The services coordinator must -

1. Contact the client, parents, or guardian if appropriate to obtain information necessary to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;

2. Contact providers to explain MHCP and billing procedures;
3. Send a letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Make sure reports are sent to primary care physician; and
5. Enter the case action into the computerized system.

4-021.06F Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the orthopedic condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-022 (Reserved)

4-023 Premature Birth Service: This service provides treatment for certain premature infants with medical complications. Note: Children referred to MHCP prematurity service must be referred to other available programs for additional services, such as the following: Remains in chapter 3, section 017 as modified

1. Early Development Network for infants and toddlers;
2. Local school districts for coordination and outreach;
3. Development TIPS; and
4. Any other services or programs who work with this population.

4-023.01 Medical Eligibility: Medical eligibility is determined on an individual case basis, considering the seriousness of the condition. The MHCP medical consultant must review all inpatient hospitalization discharge summaries for medical eligibility determination.

Covered diagnoses may include hyaline membrane disease or respiratory distress syndrome, when the client has been on mechanical ventilation for more than five days. Certain other conditions associated with prematurity may also be covered under this service. Bronchopulmonary dysplasia is an eligible diagnosis. Note: If the infant has been treated with the drug Surfactant, the infant must require a significant amount of supplementary oxygen and require other medical care usually associated with children requiring five or more days of mechanical ventilation to medically qualify for this service.

Meconium aspiration, neonatal sepsis, hypoglycemia, and neonatal meningitis are not covered. Low birth weight or gestational age by themselves do not qualify for this service. Hospitalizations for acute care or weight gain are not covered. Remains in chapter 3, sections 017.01 and 017.01(A) as modified

4-023.02 Clinics/Diagnostic Evaluations: For this service, during the first year of life, children who require developmental evaluations may be seen at MHCP sponsored clinics.

4-023.03 Certification Date: When the client is both financially and medically eligible, the certification date is the date of the birth, if the child is referred within 30 days of the date of birth. If the referral is NOT made within 30 days, the certification date will be the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 017.01(B) as modified

4-023.04 Service Components: Upon approval by the MHCP medical consultant, the following services may be authorized: Remains in chapter 3, section 017.02 as modified

1. Inpatient hospital services;
2. Inpatient pediatrician services;
3. Radiology;
4. Lab work;
5. Surgery; if performed during the authorized period of time; and
6. Ambulance services -
   a. Supplies;
   b. Equipment; and

c. Physician services during transport;
7. Nutrition assessment in the first year of life;
8. Developmental assessment in the first year of life;
9. Ophthalmology assessment in the first year of life;
10. Follow-up hearing assessment in the first year of life;
11. Feeding and swallowing evaluations;
12. Hospitalization, up to ten days after extubation; and
13. Amino acid formulas for a three-month period, for above average formula costs.

4-023.04A Criteria for MHCP Amino Acid Based Formulas: MHCP covers amino acid-based formulas for very low birth weight premature infants, below 1500 grams in weight, birth at 36 weeks gestational age or earlier. Medical problems must include hyaline membrane disease or respiratory distress requiring mechanical ventilation. Low birth weight or early gestational age by themselves does not medically qualify. The need must be evidenced by child's loss of weight, and gastroenterology evaluations showing milk/soy protein intolerance. The child must be under the care of a pediatric gastroenterologist.

MHCP only provides for the cost that is in addition to that of usual formula provided to the infant (usually based on the cost of the original formula tried and deemed not satisfactory, for example, that recommended at hospital discharge). MHCP can supplement other programs, but total provided at no cost cannot exceed the projected cost of the originally recommended/tried formula.

4-023.05 Specific Providers: Services are provided by MHCP-contracted physicians, hospitals, and other medical professionals who provide an active treatment plan.

4-023.06 Procedures

4-023.06A Medical Referrals: The services coordinator must submit any medical reports/information to the Central Office for review. MHCP Central Office staff must determine medical eligibility and return the reports to the services coordinator with eligibility coding.

4-023.06B Medical Eligibility Notification: After the services coordinator receives the coded medical information and the client is determined medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian by letter; and
2. Include a financial application in letter.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-023.06C Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation, including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-023.06D Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers; and
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send a letter to the physician in charge of care; and
5. Enter the case action into the computerized system.

4-023.06E Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to prematurity and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change; and
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01.

4-024 Rheumatoid Arthritis Service: This service provides treatment for juvenile rheumatoid arthritis and related conditions. Remains in chapter 3, section 018 as modified

4-024.01 Medical Eligibility: The services coordinator must verify medical eligibility for the diagnosis juvenile rheumatoid arthritis. The medical consultant must review all other diagnoses for medical eligibility determination. Remains in chapter 3, sections 018.01 and 018.01(A)

4-024.02 Clinics/Diagnostic Evaluations: If the client has not been examined by an MHCP-contracted rheumatologist before being referred to MHCP, the services coordinator must request that the client submit medical information from an evaluation by a rheumatologist. If a child has not been seen by a rheumatologist, any relevant medical information should be gathered as necessary and a rheumatology evaluation can be provided.

4-024.03 Certification Date: When the client is financially and medically eligible, the certification date is the referral date. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 018.01(B) as modified

4-024.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 018.02 as modified

1. Arthritis clinic/specialist evaluations, including rheumatologist, pediatrician, orthopedists, pathology, radiology and nutrition;
2. Hospitalizations and surgery;
3. Ophthalmology consultations;
4. Local pediatric/family physician care, that is, lab work, gold shots under the supervision of rheumatologist or a team;
5. Medications approved by the medical consultant (Note: Aspirin products are not covered);
6. Orthopedic devices, that is, corrective shoes and braces or if corrections of more than 1/8 inch are added to the shoes;
7. Orthotic appliances, including walkers, crutches, splints, and prostheses; and
8. Nutrition services.

If any other service components are recommended in the IMTP, the services coordinator must submit the reports to the MHCP medical consultant for approval of payment. The services coordinator must submit requests for approval of service components not recommended in the IMTP to MHCP Central Office. MHCP Central Office staff determines coverage.

4-024.05 Specific Providers: Covered services must be provided by MHCP-contracted orthopedists, pediatricians, rheumatologists, occupational and physical therapists, nutritionists, and hospitals; and MHCP-approved pharmacies. Braces, adjustments, and repairs must be provided only by companies employing certified MHCP-approved orthotists.

4-024.06 Procedures

4-024.06A Referrals: When a referral is received the services coordinator must obtain any pertinent medical information available from primary care physicians or specialty physicians. If medical eligibility cannot be determined from this information, the services coordinator must request the child obtain a diagnostic evaluation with an MHCP-contracted rheumatologist.

Using the specialist report, the services coordinator must verify medical eligibility. If further medical review is necessary, the services coordinator must submit the medical report with the medical eligibility determination inquiry to the Central Office.

4-024.06B Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian by letter; and
2. Request a financial application.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-024.06C Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter;
2. Enter the case action into the computerized system; and
3. Assist family to access other resources as necessary.

4-024.06D Certification: When the client is financially and medically eligible, the services coordinator must certify the case. The services coordinator must -

1. Contact the client, parents, or guardian, when appropriate, to obtain necessary information to authorize care and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be conducted before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;

3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers;
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send appropriate reports to the primary care physician; and
5. Enter the case action into the computerized system.

4-024.06E Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the juvenile arthritis condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition by listening and referring as appropriate;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview as required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

4-024.07 Rheumatoid Arthritis Procedures

4-024.07A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party, acknowledging the referral.

When the signed release is received, the services coordinator must request medical reports from physicians and medical facilities involved in the client's care.

If this information is received from an MHCP-contracted physician, the services coordinator must verify medical eligibility. If further review is needed, the services coordinator must send the report with the medical eligibility determination and inquiry to the MHCP medical consultant for medical eligibility determination.

If the services coordinator received a non-medical referral and the client has NOT been evaluated by the appropriate specialist, the services coordinator must contact the parents or guardian to ask them to assist in obtaining pertinent medical records, or arrange for the client to receive an evaluation by an appropriate contracted specialist which will be paid for by MHCP. These reports must be submitted to the Central Office for the MHCP medical consultant to establish medical eligibility.

4-024.07B Referrals from General Physicians or Pediatricians: When the services coordinator receives a referral from a general physician or a pediatrician, the services coordinator must determine if the client has been evaluated by the appropriate specialist.

If the client has been evaluated by the appropriate specialist, the services coordinator must verify medical eligibility. If further review is needed, the services coordinator must send the referral with medical eligibility and determination inquiry to the MHCP medical consultant for medical eligibility determination.

If the services coordinator received a non-medical referral and the client has NOT been evaluated by an appropriate specialist, the services coordinator must contact the parents, or guardian to ask them to assist in obtaining pertinent medical records, or arrange for the client to receive an evaluation by an appropriate specialist which will be paid for by MHCP. These reports must be submitted to the Central Office for the MHCP medical consultant to establish medical eligibility.

4-024.07C Referrals from MHCP-Contracted Specialists: If the referral is from an MHCP-contracted orthopedist, the services coordinator must verify medical eligibility. If further review is needed, the services coordinator must send the referral with medical eligibility and determination inquiry to the medical consultant.

4-025 Scoliosis Service: This service provides treatment for anomalies of the spine. Remains in chapter 3, section 019 as modified

4-025.01 Medical Eligibility: Eligible diagnoses include congenital scoliosis, spondylisthesis, congenital absence of vertebra, hemivertebra, and congenital fusion of the spine. The services coordinator must verify medical eligibility for these diagnoses. The MHCP medical consultant must review all other diagnoses for a medical eligibility determination. Remains in chapter 3, sections 019.01 and 019.01(A) as modified

4-025.02 Clinics/Diagnostic Evaluations: If the client has not been examined by an orthopedist before being referred to MHCP, the services coordinator must assist the family in arranging an evaluation with an MHCP contracted orthopedist, and must authorize this consultation.

If the child has already seen an orthopedist, the services coordinator must request reports asking for the diagnosis, prognosis and treatment plan. If that orthopedist is not contracted with MHCP, the family may be asked to begin treatment with a contracted orthopedist.

There are no MHCP-sponsored clinics for this service.

4-025.03 Certification Date: When the client is both medically and financially eligible, the certification date is the date of referral. Remains in chapter 3, section 019.01(B) as modified

4-025.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 019.02 as modified

1. Orthopedic office visits;
2. X-rays;
3. Scoliosis braces and maintenance;
4. Physical therapy consultation, when not provided through the school system;
5. Hospitalization if surgery is required. Note: When surgery is recommended, the child must be seen by an MHCP-contracted orthopedist recognized by MHCP as a qualified scoliosis specialist. Reports of these evaluations must be reviewed by the Central Office to determine the appropriate orthopedist to perform the surgery; and
6. Nutrition services.

4-025.05 Specific Providers: MHCP-contracted orthopedists and orthotic providers that employ certified or MHCP-approved orthotists who are able to construct scoliosis braces may provide covered components for this service. Hospitalizations must be in MHCP-contracted facilities.

4-025.06 Procedures

4-025.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request the release of medical information. A copy of the letter may be sent to the referring party, acknowledging the referral.

When the signed release is received, the services coordinator must request medical reports from physicians and medical facilities involved in the client's scoliosis care.

If this information is received from an MHCP-contracted orthopedist, the services coordinator must verify medical eligibility. If further review is needed, the services coordinator must send the report with the medical eligibility determination and inquiry to the MHCP medical consultant for medical eligibility determination.

If the services coordinator received a non-medical referral and the client has NOT been evaluated by an orthopedist, the services coordinator must contact the parents or guardian to ask them to assist in obtaining pertinent medical records, or arrange for the client to receive an evaluation by an appropriate contracted orthopedist which will be paid for by MHCP. These reports must be submitted to the Central Office for the MHCP medical consultant to establish medical eligibility.

4-025.06B Referrals from General Physicians or Pediatricians: When the services coordinator receives a referral from a general physician or a pediatrician, the services coordinator must determine if the client has been evaluated by an orthopedist.

If the client has been evaluated by an orthopedist, the services coordinator must verify medical eligibility. If further review is needed, the services coordinator must send the referral with medical eligibility determination inquiry to the medical consultant for medical eligibility determination.

If the services coordinator received a medical referral and the client has NOT been evaluated by an orthopedist, the services coordinator must contact the parents, or guardian to ask them to assist in obtaining pertinent medical records, or arrange for the client to receive an evaluation by an appropriate contracted orthopedist which will be paid for by MHCP. These reports must be submitted to the Central Office for the medical consultant to establish medical eligibility.

4-025.06C Referrals from MHCP-Contracted Orthopedists: If the referral is from an MHCP-contracted orthopedist, the services coordinator must verify medical eligibility. If further review is needed, the services coordinator must send the referral with medical eligibility determination inquiry to the medical consultant.

4-025.06D Medical Eligibility Notification: If the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian; and
2. Request a financial application;

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-025.06E Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-025.06F Certification: When the client is financially and medically eligible, the services coordinator must certify the case. The services coordinator must -

1. Contact the client, parents, or guardian, if appropriate, to obtain necessary information to authorize care and arrange the follow-up interview as required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Send authorization service providers for service;
3. Send a certification letter to the client, parents, or guardian. The letter must state -
   a. The service for which the client is certified;
   b. The certification date;
   c. Medical care eligible for payment;
   d. Authorized providers;
   e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);
4. Send a letter to the referring physician; and
5. Enter the case action into the computerized system.

4-025.06G Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the client's scoliosis condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in referrals for the psychosocial aspects of the client's condition by listening and referring as appropriate;
6. Request financial information update as needed, at least annually or when circumstances change; and
7. Continue to reassess need for other services, assist and refer as appropriate.

4-026 Urology Service: This service provides treatment for kidney, urinary, and genital anomalies determined to be chronic and disabling or potentially disabling for which active treatment is necessary. Remains in chapter 3, section 020 as modified

4-026.01 Medical Eligibility: Covered diagnoses include extrophy of the bladder, bilateral ureteral reflux, extensive hypospadias, ambiguous genitalia, and hydronephrosis. The MHCP medical consultant must review all referrals for medical eligibility determination. Remains in chapter 3, sections 020.01 and 020.01(A) as modified

When dialysis or a transplant is required, the client is eligible until dialysis begins or s/he is ready for a transplant. Normally, Medicare End Stage Renal Disease Program or other public programs begin coverage at this point; however, if the services coordinator is aware that the client is without coverage, s/he must contact the Central Office. MHCP Central Office staff must contact the appropriate program to coordinate coverage.

4-026.02 Clinics/Diagnostic Evaluations: There are no MHCP-arranged specialty clinics for this service. Diagnostic evaluations are provided by MHCP-contracted urologists or nephrologists, based on the medical consultant's recommendations.

4-026.03 Certification Date: When the client is both medically and financially eligible, the certification date is the date of referral. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 3, section 020.01(B) as modified

4-026.04 Service Components: If one or more of the following service components is recommended in the IMTP, the services coordinator must authorize payment for the component without requesting approval from MHCP Central Office staff: Remains in chapter 3, section 020.02 as modified

1. Diagnostic evaluations;
2. Inpatient hospital care;
3. Lab work;
4. Outpatient evaluations;
5. X-rays;
6. Medications;
7. Medical supplies or equipment;
8. Surgery; and
9. Nutrition services.

If any other service components are recommended in the IMTP, the services coordinator must submit the reports to the MHCP medical consultant for approval of payment. MHCP Central Office staff must determine coverage.

4-026.05 Specific Providers: Covered services must be provided by MHCP-contracted urologists and nephrologists; MHCP-contracted hospitals; and pharmacies, medical supply companies, and other providers approved by MHCP Central Office staff. Local care may be provided under the direct supervision of the specialist with MHCP Central Office approval.

4-026.06 Procedures

4-026.06A Non-Medical Referrals: When a non-medical referral is received, the services coordinator must send a letter to the client, parents, or guardian to acknowledge receipt of the referral and to request release of medical information. A copy of the letter may be sent to the referring party.

When the signed release is received, the services coordinator must request medical reports from physicians and/or medical facilities involved in the client's medical care. The services coordinator must send the reports to the medical consultant for a medical eligibility determination. MHCP Central Office staff must determine medical eligibility and return the reports to the services coordinator with eligibility coding.

4-026.06B Referrals From Physicians: The services coordinator must submit a referral from a physician to the medical consultant for review. MHCP Central Office staff must determine medical eligibility and return the report to the services coordinator with eligibility coding.

4-026.06C Medical Eligibility Notification: After the services coordinator receives the coded medical report and if the client is medically eligible, the services coordinator must -

1. Notify the client, parents, or guardian; and
2. Request a financial application and be completed.

If the client is not medically eligible, the services coordinator must notify the client, parents, or guardian of the decision. The services coordinator must enter the case action into the computerized system.

4-026.06D Financial Ineligibility: If the client is financially ineligible, the services coordinator must -

1. Notify the client, parents, or guardian of the determination by letter, citing the appropriate regulation and including the appeal paragraph in the letter; and
2. Enter the case action into the computerized system.

4-026.06E Certification: When the client is financially and medically eligible, the services coordinator must certify the case and -

1. Contact the client, parents, or guardian to explain the service, obtain necessary information to authorize care, and arrange the follow-up interview required under 467 NAC 2-002.01. Note: The follow-up interview should be completed before the certification letter is sent, whenever possible;
2. Contact providers to explain MHCP and billing procedures;
3. Send a certification letter to the client, parents, or guardian. The letter must state -

a. The service for which the client is certified;
b. The certification date;
c. Medical care eligible for payment;
d. Authorized providers; and
e. Procedure for notifying MHCP for emergency care and hospitalizations (within five working days), and for scheduled appointments and lab work (before receiving the services);

4. Send a letter to the physician in charge of care; and
5. Enter the case action into the computerized system.

4-026.06F Ongoing Services Coordination: The services coordinator must -

1. Provide authorizations as needed;
2. Request medical reports for emergency care and hospitalizations to ensure that the condition treated was related to the client's urological condition and that the care was provided or directed by authorized physicians;
3. Review medical reports for office visits and other medical care and keep medical section of the case file up to date;
4. Assist parents, medical providers, and the MHCP payment unit with questions or problems regarding bills;
5. Assist the family in dealing with the psychosocial aspects of the client's condition;
6. Request financial information update as needed, at least annually or when circumstances change;
7. Arrange and conduct the yearly personal interview required under 467 NAC 2-002.01; and
8. Continue to reassess need for other services; assist and refer as appropriate.

TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 5 MEDICAL PROVIDERS AND PAYMENTS FOR THE MEDICALLY HANDICAPPED CHILDREN'S PROGRAM AND GENETICALLY HANDICAPPED PERSONS PROGRAM

001. MEDICAL PROVIDERS. Medical providers provide services and treatment to recipients with special health care needs and receive payment for prior authorized services.

001.01 PROVIDER ENROLLMENT. Prior to services being authorized for payment, providers must sign a Department form which requires the following:

(A) The Provider must follow the Program regulations and other applicable laws;
(B) The Provider must maintain current licensing and certifications required by state law;
(C) The Provider must be screened for abuse and neglect on the child and adult central registry and must have criminal background checks completed; and,
(D) The Provider must maintain records on services provided for a minimum of six years after the date of service.

002. MEDICAL PAYMENTS. Medical payments are made to medical providers for authorized services after the Department reviews the billings for compliance with requirements.

002.01 BILLING REQUIREMENTS. The Department only considers payment for claims when the following billing requirements are met:

002.01(A) THIRD PARTY. All third party sources must be exhausted before payment may be considered.

002.01(B) REQUIRED DETAIL ON CLAIMS. The detail required on claims is dependent upon the type of medical claim being submitted. All medical claims submitted to the Department for payment must be completed in its entirety by the provider. Additional supporting documentation may be requested in order to process the claim. Failure to submit additional documentation timely will result in the claim being denied payment.

002.01(C) ACCEPT PAYMENT IN FULL. Medical providers must accept the Department's payment as payment in full. Any balance remaining on a claim after payment has been made cannot be billed to the recipient. If the Department does not make payment due to third party sources paying more than the Department's rate, the remaining balance must not be billed to the recipient. Recipients must not be billed for claims denied by the Department for untimely filing.

002.01(D) TIMELY FILING. Medical providers must bill within six months from the date of service for payment to be considered by the Department. Claims received beyond six months from the date of service will be denied.

002.01(E) REFUNDS. Medical providers have 45 days to refund any overages or erroneous payments or to show that the refunds have already been made or that the refund requests were made in error.

003. PAYMENT RATES FOR MEDICAL SERVICES. The Department follows the rates below for medical services provided while allowing the Department the discretion to negotiate rates when excessive costs are billed.

003.01 PHARMACY RATES. Pharmacy rates are as billed.

003.02 DURABLE MEDICAL EQUIPMENT. Durable medical equipment rates follow the Medicaid fee schedules.

003.03 PHYSICIAN RATES. Physician rates follow the Medicaid fee schedules.

003.04 HOSPITAL RATES. Hospital rates follow the Medicaid fee schedules.

003.05 DENTAL RATES. Dental rates follow the Medicaid fee schedules.

003.06 UNKNOWN RATES. Certain medical services do not have available Medicaid pricing. Rates that are unknown are determined by the Department on a negotiated basis until pricing becomes available.

CHAPTER 5-000 THE GENETICALLY HANDICAPPED PERSONS' PROGRAM

5-001 Introduction: The Genetically Handicapped Persons' Program provides treatment for persons age 21 or older with the genetically handicapping conditions of cystic fibrosis, hemophilia, and sickle cell disease. This centralized program follows the regulations and policies of the Title V services for medically handicapped children, with appropriate modifications for the medical care of persons age 21 or older, including contracting with specialists in adult diseases. Remains in chapter 4, section 001 as modified

5-001.01 Provision of Services: The provision of services depends on available funding. The Department may fund the following service components:

1. Initial intake and diagnostic evaluation by medical providers who are experts in the diagnosis and treatment of the particular genetic disease;
2. Medical treatment;
3. Prescription drugs;
4. Hospital care;
5. Surgical treatment;
6. Rehabilitative services including reconstructive surgery;
7. Appliances including upkeep, maintenance, and care;
8. Physical therapy; and
9. Occupational therapy.

5-001.02 Confidentiality: See 465 NAC 2-005. Remains in chapter 1, section 002.01 as modified

5-001.03 Non-Discrimination: See 465 NAC 2-001. Remains in chapter 1, section 002.02 as modified

5-001.04 Grievances and Fair Hearings: See 467 NAC 1-004 ff. Remains in chapter 1, section 002.03 as modified

5-002 Referral, Application, and Eligibility: Procedures for referral, application, and eligibility for the Genetically Handicapped Persons' Program are the same as for persons age 20 and younger (see 467 NAC 2-000). Remains in chapter 2, sections 001, 002, and 003 as modified

5-003 Cooperative Responsibilities: See 467 NAC 1-003 ff.

5-004 Limitations

5-004.01 State Institutions: The Genetically Handicapped Persons' Program does not cover care of persons residing in a state institution. Remains in chapter 4, section 001.03 as modified

5-004.02 Long Term Care: The Genetically Handicapped Persons' Program does not provide for payment to long term care facilities, including skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded. A person residing in a long term care facility may be eligible for medical services for the specific medical conditions covered by the program. Remains in chapter 4, section 001.03 as modified

5-004.03 Coordination with Other Programs: Applicants for the Genetically Handicapped Persons' Program shall apply for any other program for which s/he may be eligible (see 467 NAC 2-004.01C). Remains in chapter 2, section 003.04 as modified

5-005 Payment: For payment authorization and rates for the Genetically Handicapped Persons' Program, see 467 NAC 7-000 ff. Remains in chapter 5, section 003 as modified

5-006 Cystic Fibrosis Service: This centralized service provides treatment for adults age 21 and older with the diagnosis of cystic fibrosis. See 467 NAC 4-004 ff. Remains in chapter 4, section 002 as modified

5-006.01 Specific Providers: Covered providers are MHCP-contracted pulmonologists and the UNMC Cystic Fibrosis team. Note: 467 NAC 4-004 ff. indicates that the UNMC Cystic Fibrosis team is the only provider. For the Genetically Handicapped Person's Program, either type of contracted provider is appropriate.

5-007 Hemophilia Service: This centralized service provides treatment for adults age 21 and older with hemophilia. See 467 NAC 4-008 ff. Remains in chapter 4, section 003 as modified

5-008 Sickle Cell Disease Service: This centralized service provides treatment for adults age 21 or older with the diagnosis of sickle cell disease (sickle cell anemia). Remains in chapter 4, section 004 as modified

5-008.01 Medical Eligibility: The only covered diagnosis is sickle cell disease. Remains in chapter 4, section 004.01 as modified

5-008.02 Clinics/Diagnostic Evaluations: There are no MHCP-sponsored clinics for this program. Diagnostic evaluations are provided by MHCP-contracted hematologists.

5-008.03 Certification Date: The certification date is the date of referral if the client is receiving services from an MHCP-contracted hematologist. Exception: For a weekend or holiday admission, the referral must be received within five working days of the date of hospital admission to cover eligibility from the date of admission. Remains in chapter 4, section 004.01(B) as modified

5-008.04 Service Components: The worker shall submit Form MHC-11 to the medical consultant for approval of payment for the following service components, unless the specific service component was recommended in the IMTP approval by the medical consultant: Remains in chapter 4, section 004.02 as modified

1. Inpatient hospital care under the supervision of an MHCP-contracted hematologist;
2. Outpatient evaluations with an MHCP-contracted hematologist;
3. Lab work ordered by an MHCP-contracted hematologist; and
4. Medication, as approved by the medical consultant.

The worker shall submit requests for approval of other services to MHCP Central Office staff on Form MHC-11. MHCP Central Office staff shall determine coverage.

5-008.05 Specific Providers: Services must be provided by MHCP-contracted hematologists and MHCP-contracted hospitals. If the medical consultant approves medication, pharmacy services are covered.

5-008.06 Procedures: The procedures for this program are the same as those used for hemophilia, with the exception of the providers who must be contracted to treat sickle cell disease. See 467 NAC 4-008.06 ff.

TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 6 REFERRAL, APPLICATION, ELIGIBILITY, AND SERVICES FOR THE DISABLED CHILDREN'S PROGRAM

001. INTRODUCTION. The Disabled Children's Program serves eligible children with special health care needs and their families by providing medical support services. Family needs are assessed to determine the support services that may be covered based on available funding.

002. REFERRALS. Any individual or agency may refer children who are determined to be eligible for Supplemental Security Income benefits.

003. APPLICATIONS. Upon receiving a referral, the Department verifies Supplemental Security Income current pay status prior to applications being mailed to potential applicants. The Department must receive the completed application within 30 days after the Department mails the application. A legally responsible adult age 19 or older must complete the application. A referral is not a requirement for completing an application.

003.01 WITHDRAWAL. The applicant may voluntarily withdraw an application.

003.02 ELIGIBILITY REQUIREMENTS. The following are the eligibility requirements:

003.02(A) RESIDENT OF NEBRASKA. Applicants and recipients must reside in Nebraska.

003.02(B) CITIZENSHIP OR ALIEN STATUS. Applicants and recipients must be United States citizens or qualified aliens as required by Nebraska Revised Statute §§4-108 to 4-112. Applicants and recipients must sign an attestation form verifying lawful presence in the United States. The Department must be able to verify the status of applicants and recipients.

003.02(C) AGE REQUIREMENT. Applicants and recipients must be age 15 years or younger.

003.02(D) SUPPLEMENTAL SECURITY INCOME. Applicants and recipients must be in current pay status with Supplemental Security Income benefits.

003.02(E) NEED FOR SERVICES. Applicants and recipients must have an identified disability-related need for services.

003.03 CERTIFICATION DATE. The certification date is the date the completed application is received by the Department.

003.04 ELIGIBILITY REVIEWS. Eligibility reviews are completed annually.

004. NOTICES FROM DEPARTMENT. A notice is sent to applicants and recipients in the following instances:

(A) An applicant is determined eligible or ineligible for the program;
(B) A recipient is determined eligible or ineligible at time of redetermination; or,
(C) Services are reduced or terminated.

005. NOTICES NOT REQUIRED BY DEPARTMENT. A notice is not sent to applicants or recipients in the following instances:

(A) Services are no longer needed and applicant or recipient requests the closure;
(B) Applicant or recipient has died;
(C) Applicant or recipient becomes institutionalized;
(D) Applicant or recipient whereabouts are unknown; or,
(E) Failure to act upon request for redetermination.

006. NEEDS ASSESSMENT. Once the applicant or recipient is determined eligible, a needs assessment is completed to identify the disability-related needs of the family.

007. INDIVIDUAL SERVICE PLAN. An individual service plan is developed for each recipient based upon their needs assessment, service components of the program, and available funds. The plan details the services available to the recipient which are prior approved by the Department.

007.01 LOCATION OF SERVICES. Recipients are encouraged to use medical providers and facilities closest to their place of residence. If a medical provider or facility is available closer to the residence and the recipient chooses one further away, the Department is not obligated to pay for supportive services for that care or treatment.

007.02 SERVICE COMPONENTS. Service components may be covered based on identified needs and available funds.

007.02(A) MEDICAL MILEAGE. Medical mileage reimbursement is a covered service for families who transport recipients to disability-related medical care or treatment. Mileage for routine, general health care is not a covered service. The reimbursement rate for medical mileage follows the annual Internal Revenue Service standard mileage rate per mile driven for medical purposes.

007.02(B) LODGING. Lodging is a covered service for families who travel long distances for disability-related care or treatment for the recipient. If lodging is available through another program at no cost or minimal cost, this service may not be available. The reimbursement rate for lodging follows the annual United States General Services Administration Per Diem Rates based on the location of the lodging. Additional lodging for leisure is optional and not covered.

007.02(C) RESPITE CARE. Respite care is a covered service to provide caregivers a short break from taking care of the recipient with special health care needs. The Department determines the maximum dollar amount of respite care for each recipient based on the needs of the family and available funds, not to exceed $125 per month, which is then included in the individual service plan. Respite care may not be used as child care when a caregiver is working or going to school.

007.02(C)(i) RESPITE PROVIDERS. Parents and legal guardians of recipients are responsible for locating respite providers to care for the recipients. The following are required of all respite providers:

(1) The provider must undergo a child and an adult registry check at least once every twelve (12) months to be enrolled as a provider. The Department may require additional registry checks when the circumstances warrant further investigation. The Department may in its discretion accept a child and an adult registry check completed by another Department program within the previous twelve (12) months. Funds cannot be used to pay providers identified on the Department's child or adult registries as a substantiated perpetrator of abuse or neglect.
(2) The provider must be age 19 years or older.
(3) The provider must not reside in the household with the recipient.
(4) Non-relative providers are encouraged. The Department has the discretion to deny payment for relative providers so long as providers are available in the recipient's residing area.

007.02(D) SPECIAL EQUIPMENT AND ACCESSIBILITY MODIFICATIONS. Special equipment and accessibility modifications are covered services based on the needs of each recipient, available funds, and individual service plans. The maximum dollar amount is $3,600 per recipient's family per 12-month period. Medical necessity must be documented by a health care professional.

008. FRAUDULANT ACTIONS. The Department has the authority to terminate any relationship with a provider who has committed fraud in another government program. The Department has the authority to terminate provider relationships and deny payments to any provider that engages in fraudulent billing.

009. PAYMENTS. Payments are made to the parent or legal guardian of the recipient in specific situations and in other situations payments are made directly to the providers.

009.01 PAYMENTS TO THE PROVIDER. Payments are made directly to the provider for respite care services, special equipment, and accessibility modifications. Billing documents must be completed accurately and received by the Department timely, within 60 days from the date of service, in order to be considered for payment. Billings received by the Department after the 60 days from the date of service will be denied payment. One billing document must be completed for each month for each type of service authorized. Special equipment and accessibility modifications are paid once the purchase or project is complete to satisfaction of the family. Inaccurate or incomplete billing claims may be denied.

009.02 PAYMENTS TO THE RECIPIENT'S PARENT OR LEGAL GUARDIAN. Payments are made as reimbursement to the parent or legal guardian of the recipient for medical mileage and lodging services. Billing documents must be completed accurately and received by the Department timely, within 60 days from the date of service, in order to be considered for payment. Billings received by the Department after the 60 days from the date of service will be denied payment. One billing document must be completed for each month for each type of service authorized. Inaccurate or incomplete billing claims may be denied.

CHAPTER 6-000 THE SUPPLEMENTAL SECURITY INCOME -- DISABLED CHILDREN'S PROGRAM (SSI-DCP)

6-001 Introduction

6-001.01 Scope of Program: The SSI-Disabled Children's Program serves children who receive monthly SSI grants and their families by providing needed services to meet the program-specified outcomes of empowerment, care assistance, stress reduction, and access to medical supports. Services provided are based upon a needs assessment plan jointly established by the family and the services coordinator, taking into consideration availability of funding. This needs assessment is shown in the child's Individual Service Plan (ISP), or other jointly-established plan with similar information (e.g., Early Intervention's Individualized Family Service Plan (IFSP)). Remains in chapter 6, sections 001 and 006 as modified

Authorized services must not be available through other agencies and must be related to any chronic or congenital disabling condition the child may have. Routine health care is not covered.

6-001.02 Grievances and Fair Hearings: See 467 NAC 1-004. Appeals regarding Social Security eligibility must be made to the Social Security Administration (SSA). Appeals to the Department may only be made on the service plan or provision of service. Remains in chapter 1, section 002.03 as modified

6-001.03 Responsibilities of the Department

6-001.03A Central Office Responsibilities: Central Office staff shall -

1. Route referrals received by Central Office to the appropriate district office;
2. Provide consultation and participation in decision-making teams, as appropriate;
3. Review submitted service plans in terms of outcomes, training needs, and budget requirements; and
4. Process billings.

6-001.03B Services Coordinator Responsibilities: The services coordinator shall -

1. Receive all referrals of SSI-eligible children;
2. Ensure that the family of each SSI-eligible child receives appropriate information about and referral to available services;
3. Participate in the development of a plan to meet identified needs;
4. Provide funding to eligible children for service(s) which cannot be obtained from another source (see 467 NAC 6-005);
5. Coordinate services with other agencies; and
6. Initiate and maintain the case file and narrative.

6-001.04 Responsibilities of the Child's Parent or Guardian: The parent(s) or guardian of the child who is receiving services through the SSI-Disabled Children's Program shall – Remains in chapter 1, section 002.04 as modified

1. Participate in the development of a plan to meet identified needs and follow through, as indicated;
2. Contact the services coordinator within 10 days if –
   a. The family situation or address changes; or
   b. Problems exist in obtaining or using services;
3. Respond to contacts by DCP-designated staff; and
4. Cooperate in providing necessary information to the Department.

6-001.05 Summary of Forms: The following forms are used in the SSI-Disabled Children's Program. Instructions for these forms appear in the appendix.

Form #	Form Title	Appendix Reference
ASD-17	Question Referral	467-000-1
DSS-6	Notice of Action	467-000-10
MHC-3	Request for Coordinated Services/Devices	467-000-13
MHC-24	Billing Document	467-000-34

6-002 Referrals: The services coordinator shall accept referrals of SSI-eligible children from – Remains in chapter 6, section 002 as modified

1. Parents/guardians whose children have been determined eligible for SSI benefits;
2. Parents/guardians who previously declined services;
3. Parents/guardians whose former SSI-DCP cases have been closed;
4. Central Office, via SSA and the State Disability Determination Section (DDS); or
5. Any other source who knows of an eligible child in need of services.

6-002.01 Verification of SSI Status: If there is any question about the child's SSI eligibility, the services coordinator shall confirm SSI payment status before contacting the child's parent/guardian.

6-003 Eligibility: Children served by SSI-DCP must reside in Nebraska, be age 15 or younger, be eligible for SSI benefits, and have an identified disability-related need. Remains in chapter 6, section 003.02 as modified (includes sections 003.02(A), 003.02(C), 003.02(D), and 003.02(E))

6-003.01 Needs Assessment: The SSI-DCP services coordinator determines services eligibility based on assessed needs and that all other points of eligibility (e.g., SSI benefit, age, residence) are met. The services coordinator assists the family to assess all needs and develop a plan to meet those needs. To address needs with DCP funds, the services coordinator shall follow outcome, service, and needs assessment criteria (see 467 NAC 6-006). Remains in chapter 6, section 006 as modified

6-004 Application Remains in chapter 6, section 003 as modified

6-004.01 Initial Contact: When the services coordinator receives a referral from a source other than the parent/guardian, s/he shall verify the SSI-eligibility and contact the parent/guardian within 14 calendar days to discuss the referral and provide general information about SSI-DCP.

6-004.01A No Response: If the contact was made by mail and no response is received within two weeks, the services coordinator shall send a second letter, explaining that the referral will be considered informational only, unless the parent makes contact.

6-004.01B Parent/Guardian Interested: If the child's parent/guardian expresses interest in SSI-DCP, the services coordinator shall send an application (Form MHC-3) as soon as possible and arrange to conduct a face-to-face visit within 30 days of the parent/guardian request.

6-004.01C Parent/Guardian Not Interested: If the child's parent/guardian responds that the family is not interested in participating in the SSI-DCP, the services coordinator shall document the decision in the case record narrative and consider the referral as informational only.

6-004.02 Application Completion

6-004.02A Face-To-Face Visit: If no other jointly determined comprehensive plan exists for the family, the services coordinator shall conduct an interview with at least one of the child's parents or his/her guardian in a location jointly decided by the services coordinator and the family to -

1. Explain the SSI-Disabled Children's Program;
2. Provide assistance in completing Form MHC-3, "Request for Coordinated Services/Devices;"
3. Discuss the needs described on the application as well as any other identified needs; and
4. Jointly develop an individual service plan (see ISP, 467 NAC 6-004.03). If the family already has a designated case manager and/or comprehensive plan through another program (e.g., an IFSP through the Early Intervention Program), the services coordinator shall participate in partnership, as appropriate, with the already-existing effort and obtain a copy of the plan which includes DCP-funded services.

If possible, the services coordinator should meet the child during this visit.

6-004.02B Early Intervention Involvement: If a child is receiving services coordination through Early Intervention, the assessment provided through the Individualized Family Service Plan (IFSP) process meets DCP requirements for a face-to-face visit. The services coordinator may be involved as a member of the IFSP team or may only offer technical assistance and program-specific support to the services coordinator/family.

6-004.02C "Mileage Only" Application Exception: Upon request for disability-related mileage-reimbursement for an SSI-eligible child, the services coordinator shall conduct an office or telephone assessment (or mail, if the family has no telephone) of the medical need for long-distance travel. Based upon reimbursement of 20 cents per mile, and map-shown mileage between destinations, the services coordinator shall determine whether the family typically incurs $25 or more per month in mileage costs. If so, the services coordinator shall mail an application to the family. Upon receipt of the signed application, the services coordinator shall provide an authorization letter to the family, authorizing them to bill for the full amount in any calendar month in which travel expenses total $25 or more.

No face-to-face visit or ISP is required for children whose families request only mileage reimbursement. If any other service(s), including meals and lodging, are requested, the services coordinator shall complete a home visit, application, and plan, as usual.

See also 467 NAC 6-008.09.

6-004.03 Individual Service Plans (ISP): If a jointly-developed, comprehensive plan does not already exist, the services coordinator shall assist the family to develop an individual service plan. (See 467-000-13, page 5.) Remains in chapter 6, section 007 as modified

Each individual service plan must include, but is not limited to -

1. The child's name and social security number;
2. The services coordinator's name and telephone number;
3. The effective date and end date of the plan; and
4. A description of each request listed on the plan, actions that have been or will be taken and by whom, and the amount of service funding authorized through DCP.

6-004.03A Plan Distribution: If Form MHC-3 is used, the plan is formatted as a separate page which may be provided to the family at the end of the visit. The services coordinator shall also submit a copy of the ISP to Central Office.

6-004.03B Changing the Individual Service Plan: Whenever the services coordinator and family jointly determine that a change is needed in the service plan, the services coordinator shall document the change and provide a copy to the family.

6-005 Coordination with Other Programs: The services coordinator shall make all reasonable efforts to coordinate the use of existing services and to obtain funding from any other program which may provide services to the child. Any federally-funded program which is available to meet the child's need must be utilized instead of SSI-DCP funds. Federally-funded programs include Title V (MHCP), Title XIX (Medicaid), and Social Services Block Grant (Title XX).

The parent(s)/guardian must apply for other programs available to meet the child's disability-related needs (see 467 NAC 2-004.01C).

6-006 Needs Assessment Criteria: The services coordinator shall discuss the following criteria with the family to determine the need for services through SSI-DCP -

1. The child's medical, social, developmental, rehabilitative, and referral needs;
2. The family's potential for maintaining the child in the family home;
3. The extent to which a requested item or service is necessary to maintain the child in the home as independently as possible;
4. The extent to which an interruption of services or not initiating services at this time will have an adverse effect on or delay progress toward becoming self-sufficient or self-supporting;
5. The severity of the disabling condition;
6. The degree to which the child can readily benefit from the services; and
7. The availability of other resources such as -
   a. Family members or caregivers who can meet identified needs;
   b. Other relatives, friends, or volunteers who will provide identified needs at no cost;
   c. Services already in place for the child or other programs for which the child may be eligible (e.g., MHCP, special education, or Social Services Block Grant, Medicaid Waiver); or
   d. Other programs which have assumed responsibility for the child by supporting out-of-home placements or through court actions altering parental responsibilities.

Note: When appropriate service is available through an agency with a sliding fee scale, families are encouraged to use that agency. DCP funds cannot be used to pay the amount the agency has determined to be the family's responsibility.

After need for service has been established using the general criteria, the services coordinator and the family shall jointly determine the appropriate program outcome(s) toward which the family is working and DCP-funded services are directed and document the outcome(s) in the case file.

6-006.01 Empowerment Outcome: The family gains self-confidence and the knowledge necessary to make their own decisions about the child's special care needs and access needed services.

This outcome is supported by the following case management or purchased DCP services:

1. Listening;
2. Assisting with decision making and problem solving;
3. Providing resource information and referral;
4. Serving as family advocate and liaison with other Department, public, and community resources and programs, as requested and appropriate; and
5. Purchasing training.

6-006.01A Measurements: This outcome may be measured as follows:

1. Parents report an improved knowledge and feelings of increased competence and ability to problem solve.
2. Better community involvement and appropriate integration into service systems for the family.
3. Fewer inappropriate telephone calls by the family to the services coordinator.
4. Less case management time and effort.
5. Fewer "non-emergency" emergency room visits.

6-006.02 Care Assistance Outcomes: Families are better able to care for children in their homes.

This outcome is supported by the following case management or purchased DCP services:

1. Purchasing special equipment;
2. Purchasing home modifications;
3. Providing home visit leading to assessment of physical environment or need for in-home services;
4. Providing resource information and referral;
5. Serving as family advocate and liaison with other Department, public, and community resources and programs, as requested and necessary; and
6. Purchasing relative-provided personal care.

6-006.02A Measurements: This outcome may be measured as follows:

1. Positive statements from parents about ease of care.
2. Reduction in needed ongoing services.
3. Family decides against institutionalization.
4. Proper medical care is received (e.g., appointments are kept, follow-up care recommendations are completed).

6-006.03 Stress Reduction Outcomes: Families are able to deal more effectively with their child's special care needs with reduced stress within the household.

This outcome is supported by the following case management or purchased DCP services:

1. Listening.
2. Assisting with decision making and problem solving.
3. Serving as family advocate and liaison with other Department, public, and community resources and programs, as requested and appropriate.
4. Conducting home visits to assess needs.
5. Providing resource information and referral.
6. Purchasing respite care.
7. Purchasing home modifications.

8. Purchasing special equipment.
9. Purchasing training.
10. Purchasing respite care for siblings.
11. Purchasing relative-provided personal care.
12. Purchasing attendant care.

6-006.03A Measurements: This outcome may be measured as follows:

1. Parents' report.
2. Family remains intact.
3. Health status of parents and siblings.
4. Fewer crisis telephone calls by the family to the services coordinator.
5. Adjustment in the amount of respite care hours used, in relation to assessed needs.
6. Reports of less job absenteeism.
7. Reduced CPS involvement.

6-006.04 Medical Outcomes: Families are able to obtain specialized medical care for their children.

This outcome is supported by the following case management or purchased DCP services:

1. Assisting with decision making and problem solving.
2. Serving as family advocate and liaison with other departments, public, and community resources and programs, as requested and appropriate.
3. Conducting home visits to assess need.
4. Providing resource information and referral.
5. Reimbursing families for medical mileage.
6. Purchasing commercial transportation.
7. Reimbursing families for extraordinary telephone charges related to medical care.
8. Purchasing meals and lodging.
9. Purchasing special equipment.
10. Purchasing respite care for siblings.
11. Purchasing training.
12. Purchasing ramps for home accessibility.

6-006.04A Measurements: This outcome may be measured as follows:

1. Child receives proper medical care (e.g., family keeps medical appointments, family follows through on medical recommendations/treatment plans).
2. Parents report feelings of increased competence and ability to support medical care needs in their home.
3. Reports of child death do not indicate neglect or lack of care.
4. A decrease occurs in the number and/or length of hospitalizations.
5. A decrease occurs in the number of emergency room visits.
6. A decrease occurs in the rate of child protective services reports regarding SSI-eligible children.
7. School attendance is improved or maintained.

6-007 Service Authorization: The services coordinator shall prior authorize all services for individuals under the SSI-Disabled Children's Program and retain a written record of the authorization in the individual's case file. Prior authorization is given via the computerized MIS or on Form MHC-24, "SSI-Disabled Children's Program Billing Document," as appropriate. For ongoing types of service, the services coordinator may provide an adequate supply of Form MHC-24 for monthly billings. (See also 467 NAC 6-011.03.)

The services coordinator shall not authorize payment for any service provided or item purchased before the services coordinator was made aware of the need. All services authorized by DCP must be included in the child's service plan.

6-007.01 Decision-Making Team: When the services coordinator needs consultation on meeting needs of an eligible child/family or determines that a requested service would exceed the following costs, s/he shall create a decision-making team:

1. The cost of an item or the monthly total for a type of assistance would exceed $150, when no other limitation exists for the service type;
2. More than $75 a month per family for respite care for the DCP-eligible child is needed under special circumstances (467 NAC 6-008.01);
3. A decision-making team determines the appropriateness of proposed architectural modifications whenever a job is bid at $500 or less; and
4. When a job is bid at $500 or more, the services coordinator shall obtain an assessment from an Independent Living Specialist. When additional information is gathered through the Independent Living Specialist or Central Office review, the services coordinator shall convene a decision-making team.

A team is a three-person, telephone, in person, or via automation-connected unit, consisting of the DCP services coordinator with an issue to discuss, one other districts' DCP services coordinator (contacted on a rotating basis), and a program representative. The three would discuss the specific issue and reach a majority decision on direction. One member would be assigned to inform all DCP-involved staff, if the decision seems precedence-setting.

6-007.02 Priority Criteria: In an effort to focus on program outcomes (467 NAC 6-006 ff.), decision-making teams may evaluate requests to determine priorities consistent with available funding. Each high-cost request must be evaluated and a priority determination made using criteria which include but are not limited to -

1. The potential for the family maintaining the child with a disability in the family home;
2. The extent to which this item/service is necessary to maintain the child in the home as independently as possible;
3. The cost of providing requested assistance;
4. Other concurrent needs identified by the family; and
5. Other payments (both DCP and other) which are being made or have been made on behalf of the child for disability-related needs.

6-007.03 Eligibility Period: The services coordinator shall determine the effective date of services to be authorized to meet the needs identified in the service plan. This is the earliest date payment for service can be covered. This date may be as early as the date the services coordinator received the referral and extend for one year. Remains in chapter 6, sections 003.03 and 003.04 as modified

6-008 Outcome-Based Services

6-008.01 Respite Care Remains in chapter 6, section 007.02(C) as modified (includes an increase in the maximum monthly amount of $125 per recipient)

6-008.01A Respite Care for the DCP-Eligible Child: The following conditions apply to authorization and receipt of respite care as a DCP-funded service for the DCP-eligible child:

1. A maximum of $75 a month applies per family. A larger amount may be approved by a decision-making team under special circumstances (e.g., the child's care needs require a health care professional, the family includes more than one SSI-DCP eligible child).
2. Based on a needs assessment, determined jointly with the family, a monthly amount less than $75 must be considered for families with two or more available helping adults; when the child is in school at least four hours per day; or when the caregiver is employed outside the home. When large amounts of personal care aide or other in-home assistance are required by the household, an adjustment may also be appropriate--less if needs are being met, or more if care needs are extraordinary.
3. Respite care is not intended to support a concentrated effort by a parent to obtain a degree or some other educational pursuit. If a parent wants to take a class as a means of relaxation or "time-out," use of respite care may be appropriate.
4. Families may "save" two months' respite allowance to "spend" on a larger block of time in a third consecutive month (e.g., family vacation).

6-008.01B Respite Care for Siblings: DCP funds may be appropriately authorized and received to pay the costs of child care for the brother(s) and/or sister(s) of the SSI-eligible child to allow the parent(s) to accompany the SSI-DCP child to medical treatment or care.

Services coordinators shall refer sibling care costs to other resources or no cost programs (e.g., DSS-funded child care, Social Services Block Grant homemaker, or friends and relatives), as appropriate. In the absence of other alternatives, services coordinators may authorize sibling care.

Usual and customary child care rates in the community are the basis for sibling care payments. A daily rate should be negotiated when the number of consecutive hours of care exceeds six.

6-008.02 Training: DCP funds may be authorized to cover the cost of training for parents in specific skills which are related to the child's disability until the parent achieves sufficient proficiency to care for the child at home. Costs for attendance at conferences related to the disability are not covered. For example, payment for a parent to attend a class to learn sign language could be covered, while costs would not be allowed for attending an informational conference on children with hearing impairments.

6-008.03 Special Equipment: The following conditions apply to authorization and receipt of special equipment as a DCP-funded item: Remains in chapter 6, section 007.02(D) as modified

1. Services coordinators may authorize a maximum of $3,600 per family per 12-month period, beginning with the effective date of the current service plan, in a combination of special equipment and home accessibility, working with each family to determine the single highest priority need. Costs within this maximum allowance include the initial evaluation/assessment to determine appropriate item, purchase price, installation, and repair of special equipment.
2. Services coordinators shall not authorize DCP funds until all other possible funding resources for purchase of equipment have been thoroughly explored.

3. All requests for special equipment must be referred to Assistive Technology for evaluation and services to be paid by DCP.
4. Special equipment may include but is not limited to -
   a. Van lifts. The services coordinator shall consult with a decision-making team regarding the type of lift and cost, and the age, condition, and mileage of the van into which the lift will be installed. If the van is more than five years old, or if the family plans to get a different van within the next few years, the services coordinator shall investigate whether the lift can be transferred to a different van and the most appropriate lift to facilitate this transfer. A van lift may be purchased for a family only one time in a five-year period. DCP funds may also be authorized to cover the cost of van lift installation and related needs (e.g., tie downs).
   b. Used van, porch, or stair lifts. These may be purchased, following an evaluation by a qualified expert (e.g., League of Human Dignity, Assistive Technology Project). Van lifts may be already installed or available separately. DCP may authorize payment up to the estimated value of the lift.
   c. Air purification systems, air conditioners: DCP funds may be authorized for the purchase of air purification systems or air conditioning only if a child's allergy is severe enough to meet MHCP criteria for asthma service or if asthma is the single qualifying disability for SSI. If the child is not eligible for MHCP, the services coordinator shall obtain approval from the MHCP medical consultant.
   d. Positioning equipment; bath aids: These items may be considered for purchase/reimbursement through DCP if medical necessity is evidenced by a statement obtained from a physician or therapist, as appropriate, detailing the benefits expected.

If the services coordinator has a question about medical necessity, s/he shall consult with the MHCP nurse consultant at Central Office.

6-008.03A Excluded Items: The services coordinator shall not authorize DCP fund expenditure for the following:

1. Telephone devices for the deaf (TTDs, TTYs).
2. Television closed caption devices.
3. Pagers or cellular phones..
4. Computers or computer software.
5. Therapeutic toys.
6. Routine costs of maintaining special equipment (e.g., no funding for wheelchair batteries, annual clean and check of central air conditioning).
7. Portable ramps.

6-008.04 Home Accessibility: Services coordinators may authorize a maximum of $3,600 per family per 12 month period, beginning with the effective date of the current service plan, in a combination of special equipment and home modifications. Staff shall work with each family to determine the single highest priority need. Total DCP payments for a single item or project must not exceed the $3,600 yearly maximum. The following conditions apply to authorization and receipt of home accessibility as a DCP-funded service: Remains in chapter 6, section 007.02(D) as modified

1. All requests for home modifications must be referred to Assistive Technology for evaluation and services to be paid by DCP.
2. For any home accessibility modifications, information is needed on whether the home is owned by the family or rented. If rented, the services coordinator shall consider how long the family has lived there, history of their moving pattern (every year, frequently, etc.), the availability of other accessible rental options in the community, and whether the landlord has agreed to the modification in writing. A copy of the landlord's permission must be included in the child's file.
3. DCP will only consider making one entrance to the home accessible. If one entrance to the home is accessible, DCP does not cover the cost to make another accessible entrance.
4. Home modification is limited to accessibility and usability for the child with the disability. Payment for construction of new rooms, making a room out of an existing area, making a second living area or level accessible, making a second accessible bathroom, or additions to a home are beyond this scope. However, DCP can consider covering the cost of accessible fixtures (such as accessible toilet, sink, or shower) when a room or addition is being built and the actual construction of the room is funded by another source (e.g., the family, another program).

For jobs bid at $500 or less, the services coordinator shall discuss the situation with a decision-making team to determine the appropriateness of the proposed modifications.

6-008.04A Excluded Modifications: Services coordinators shall not authorize DCP fund expenditures for the following home modifications:

1. Requests which would result in isolation of the child (e.g., construction or repair of fences, a room for the child separate from the family's living area, padded walls);
2. Portable ramps; and
3. Modifications not related to making the child's home physically accessible.

6-008.05 Personal Care: Personal care services may be authorized through DCP only when the service is not available to the child through the Medicaid program. This is expected to be limited to times when the preferred provider is a relative of the child who needs service.

6-008.06 Attendant Care: Attendant care is assistance in caring for the DCP-eligible child. It may be authorized if each parent is employed or going to school. (Going to school is defined in Social Services child care as enrolled in and regularly attending vocational or educational training to obtain a high school or equivalent diploma or an undergraduate degree or certificate designed to fit him/her for paid employment. This excludes students pursing second undergraduate degrees, second certificates, or any post-graduate schooling.)

The services coordinator and/or family shall explore eligibility for Social Services child care before attendant care may be authorized through DCP. Medicaid personal care aid must be explored, when appropriate, and used instead of DCP attendant care. For a hospitalized caregiver, or recovering caregiver, Social Services homemaker should be explored before attendant care is authorized through DCP.

Payments are never made to the parents as providers.

Attendant care is provided, following a needs assessment, for two categories of need:

1. Child. Only the disability-related cost of attendant care is covered when the service is provided to enable the usual caregiver to be employed or attend school. If the child would require care or supervision regardless of disability because of the parent's absence, and the parent would normally pay a lesser charge per day, DCP funds may be used to cover the costs of extraordinary charges. For example, if the parent would normally pay $10 per day, but because of the disability the provider charges $15 per day, the $5 per day difference could be paid through DCP as a disability-related attendant care expense.
2. Youth. For youth who require care and supervision during a parent's absence for work or school, solely due to their disability rather than to age, DCP funds may be used to cover the full costs of attendant care. General guidelines indicate that a child is normally considered to not need supervision on an ongoing basis at age 12 or older.

6-008.07 Medical Mileage Reimbursement: Medical mileage reimbursement is available to parents who transport their children to disability-related medical care or treatment. Mileage is reimbursed at a rate of 20 cents per mile. Remains in chapter 6, section 007.02(A) as modified

Transportation costs cannot be covered when travel is within the metropolitan area in which the child lives or when total mileage expenditures are less than $25 per month. The services coordinator may authorize exceptional transportation costs when daily or very frequent trips are necessary and the trip is more than a few miles each way (e.g., south Omaha to Children's Hospital every day for two weeks).

6-008.08 Commercial Transportation: When the child's condition is life threatening or surgery is being performed and the presence of the second parent is warranted, DCP may fund the second parent's commercial transportation.

Transportation costs are not covered by DCP in the following instances:

1. DCP funds cannot be used to purchase service from a provider (e.g., airline, taxi, or individual) for the first parent. This service is funded through Social Services Block Grant/Medicaid.
2. Parking is not covered by DCP.

6-008.09 Meals and Lodging: Meals and lodging expenses for a Medicaid-eligible child and his/her attendant (e.g., one parent) are available through Medicaid when the meals and lodging are provided by a hospital which is enrolled as a Nebraska Medicaid ambulatory board and room provider. DCP funds are not available for parents' meals and lodging when care is provided by a Medicaid ambulatory board and room provider. The only exceptions are when the child's condition is life threatening or surgery is being performed and the presence of the second parent is warranted or when a second attendant is medically necessary. In this case, DCP may fund the second parent's meals and any additional lodging cost. Remains in chapter 6, section 007.02(B) as modified

When a child will travel to receive care at a facility which does not contract with Medicaid as an ambulatory room and board provider, DCP funds may be authorized for reimbursement during calendar months in which these costs exceed $25. For example, if meals are purchased for two days during January, totaling $24, none of the cost is covered. If meals are purchased for five days in February, the entire $60 is reimbursable.

Lodging rates are based on actual expenditures up to the State reimbursement rate. Meals expenditures are limited to $20 per day per attendant (usually the parent). Additional expenditures for meals and lodging for siblings is not allowed. Cost of sibling's meals may be included in the parent's daily allowance, but an additional allowance for a sibling is not allowed.

DCP funds cannot be authorized to cover expenditures of paid providers (e.g., personal care aides, medical escorts). The rate of pay allowed those attendants should reflect the cost of providing service.

6-008.10 Utilities

6-008.10A Telephone Expenses: DCP can consider covering the cost of phone installation, ONLY if the child will not be released from the hospital without telephone service at home.

If the family has identified a need for assistance due to high long distance telephone costs, DCP can pay for long distance charges from the family to medical personnel or facilities which are currently involved in the child's treatment plan which is related to the disability.

6-008.10B Electricity Costs: If a family requests assistance with electric bills due to high costs related to the use of special equipment (e.g., a ventilator) or because the child has asthma severe enough to qualify for MHCP asthma service or if asthma is the single qualifying disability for SSI, DCP funds may be used to pay a portion of the electric bill.

The services coordinator shall use the following formula to determine the amount covered by DCP:

1. If the family is eligible for a heating/cooling program, add $35 (if the family lives in a multi-family dwelling) or $55 (if the family lives in a single-family dwelling) to the monthly amount of heating/cooling assistance. Deduct that sum from the family's monthly electric bill. DCP funds may be authorized to cover the difference as a disability-related expense.
2. If the family is not eligible for a heating/cooling program, subtract $35 (if the family lives in a multi-family dwelling) or $55 (if the family lives in a single-family dwelling) from the family's monthly electric bill. DCP funds may be authorized to cover the balance, as a disability-related expense.

If the services coordinator has a question about medical necessity, s/he shall consult with the MHCP nurse consultant at Central Office.

6-009 Redetermination

6-009.01 Annual Review: The services coordinator shall annually review each child's needs and service plan, meeting with the parent(s)/guardian and the child in any convenient location. Reviews must take place annually, beginning from the effective date of the service plan (see 467 NAC 6-007.03). Remains in chapter 6, section 003.04 as modified

6-009.02 Change in Circumstances: The services coordinator shall complete a redetermination of eligibility when information is obtained about changes in a family's circumstances that may change the child's eligibility. The services coordinator shall complete this review as soon as possible and within 30 days.

6-010 Denial, Reduction, or Termination of Services Remains in chapter 6, sections 004 and 005 as modified to read under "Notices"

6-010.01 Denial or Reduction: If a requested service (i.e., a request included on the service plan) is denied funding through DCP or funding levels will be reduced, the services coordinator shall provide notice of action to the family using Form DSS-6. If services are being reduced, the services coordinator shall provide the notice at least ten calendar days before the effective date.

6-010.02 Termination: When a child's SSI-DCP case is to be terminated, the services coordinator shall immediately provide written notice to the parent/guardian, using Form DSS-6, at least ten calendar days before the termination's effective date. The notice must include information about -

1. The effective date;
2. Services terminated;
3. The reason for termination; and
4. The family's right to appeal.

No notice is required when the service plan is scheduled to expire and no further services are needed.

6-010.02A Reasons for Termination: The services coordinator shall immediately notify the parent/guardian of termination of SSI-DCP benefits when -

1. The child's eligibility for SSI benefits has been terminated. The services coordinator shall allow ten days notice of adverse action unless -
   a. Services have been started and the service plan indicates that the commitment of monies was made for the service in a written authorization for the specific service before receipt of the notice of termination (e.g., a piece of equipment has been ordered, but not yet delivered or a bid for architectural modification has been accepted);
   b. Abrupt termination of the medically-related services being provided would prevent the completion of a specific medical plan (e.g., meals and lodging have been authorized for an already-scheduled medical trip); or
   c. SSI benefits are discontinued for a period not to exceed six months. The services coordinator shall consult with a decision-making team to continue payment beyond six months.
2. The parent/guardian fails to comply with the service plan. The services coordinator shall provide the parent/guardian ten days advance notice of termination.
3. A needs assessment determines that service needs no longer exist. The services coordinator shall provide the parent/guardian ten days advance notice of termination.
4. Services available through SSI-DCP are discontinued due to budget restrictions.

5. The child moves from Nebraska.
6. The child is placed in foster care with no immediate plans for reunification.
7. The child is institutionalized for an indefinite period.
8. The child becomes a state ward.

Services also terminate upon the death of the child and if whereabouts are unknown. Services coordinator discretion is allowed in the provision of notice for those reasons (e.g., providing notice to a provider, mailing to the last known address). The action must be documented in the case record.

6-010.03 Providing Referral: The services coordinator shall make all reasonable efforts to refer children whose service is denied, reduced, or terminated and who require additional services to other agencies which can provide services.

6-011 Payment for Services: SSI-DCP payments may be provided as vendor payments to qualified providers or made as reimbursements to the parent/guardian for services which s/he has provided (i.e., transportation) or for prior authorized items or services purchased in advance of billing to SSI-DCP. Remains in chapter 6, sections 009.01 and 009.02 as modified

6-011.01 Provider Standards: SSI-DCP providers shall follow the policies in 467 NAC 7-000. If the provider does not participate in MHCP, s/he shall meet any applicable local, state, or federal laws and regulations.

6-011.02 Abuse/Neglect Registry Checks: DCP funds cannot be used to pay a direct care provider (e.g., respite care, attendant care) or reimburse a family for services from a direct care provider if that provider is identified on the Department's child or adult registries as a substantiated perpetrator of abuse/neglect. The services coordinator shall conduct such a search before authorizing DCP funds. This includes – Remains in chapter 6, section 007.02(C)(i) as modified

1. Explaining to both families and providers that an abuse/neglect registry check is required for any provider who will provide direct care and supervision of children.
2. Obtaining the name of each potential provider of direct care before service is authorized through DCP.
3. Obtaining signed consent from the provider, allowing his/her name to be checked with both the child and the adult registries.
4. Accessing, or arranging access to, the automated registries.
5. If no match is found: Notifying the provider and family that service may begin.
6. If a match is found: Notifying the provider and family that DCP funds are not available. The services coordinator shall explain to the provider proper procedures to request a record expungement through protective services staff in Central Office.

6-011.03 Billing: Either the provider or the parent/guardian may bill SSI-DCP by submitting Form MHC-24 or the provider's regular billing document.

The services coordinator shall retain a copy in the child's case file and forward the original to Central Office for payment.

TITLE 467 - MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 7 - (Repealed)

CHAPTER 7-000 MHCP PROVIDERS

7-001 Introduction: MHCP contracts with approved providers. Contracts are required for certain types of providers for two different types of services: medical treatment services and clinical and treatment planning services. Contracts are offered to individual providers or to certain institutions employing specific providers. Information remains about using a Department form to ensure providers follow requirements—Remains in chapter 5, section 001.01 as modified

Providers of other MHCP services must be approved by MHCP Central Office staff.

MHCP monitors and reviews providers as necessary to ensure compliance with MHCP regulations.

This chapter contains MHCP's regulations for provider participation, including general requirements, the contracting process, the approval process, specific provider requirements, authorization of payment, and payment rates.

7-002 General Requirements for Participation: Each provider must -

1. Provide services according to the regulations of the Nebraska Department of Health and Human Services for MHCP and in compliance with state and federal law; Remains in chapter 5, section 001.01(A) as modified
2. Provide services in compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Nebraska Fair Labor Employment Practice Act, all as amended;
3. Accept as payment in full the rate established by the Nebraska Department of Health and Human Services for MHCP after all other sources have been exhausted; Remains in chapter 5, section 002.01(C) as modified
4. Submit bills within 60 days of the date of service; Remains in chapter 5, section 002.01(D) but modified to allow timely filing within 6 months which aligns with Medicaid regulations
5. Maintain records on all services provided for which a claim has been made for four years after the date of service to allow on-site inspection, and furnish, on request, the records to the Nebraska Department of Health and Human Services, the federal Department of Health and Human Services or other agencies so designated. Providers must document services before billing the Department; Remains in chapter 5, section 001.01(D) as modified for records to be kept 6 years instead of 4 years
6. Provide and maintain quality, necessary, and appropriate services within acceptable medical community standards and/or accepted national standards for specific services as determined by a body of peers, medical review teams, or investigations conducted by or under contract with MHCP;
7. Repay or make arrangements for repayment of identified overpayments or otherwise erroneous payments. The provider has 45 days to refund the requested amount, to show that the refund has already been made, or to show why the provider feels the refund request may be in error; and Remains in chapter 5, section 002.01(E) as modified
8. Accept the termination or reduction of his/her contract in the event that funds to finance his/her contract become unavailable due to reductions in state or federal funds.

7-003 Contracting Process: This subsection contains the steps MHCP Central Office staff must follow to contract with a provider and the requirements a provider must meet before MHCP may offer a contract.

7-003.01 Requests: Any individual may request MHCP Central Office staff to consider contracting with a provider.

7-003.02 Response: MHCP Central Office staff must respond to a request for an MHCP medical provider contract within 30 days of receipt of the request. This response may be a request to provide additional information.

7-003.03 Evaluation: MHCP Central Office staff must determine whether to consider contracting with this provider. This decision is based on -

1. MHCP coverage of services offered by this provider;
2. Whether an individual contract is necessary; and
3. MHCP's need for this provider's services.

7-003.04 Provider Eligibility: If MHCP will consider contracting with a provider, MHCP Central Office staff must determine that the provider meets the following eligibility requirements:

1. The provider must be licensed and/or certified as required by state law;
2. The provider must meet any applicable state or federal law governing the provision of his/her services; and
3. The provider must not be under sanction by Medicare or Medicaid, or the Nebraska Department of HHS Regulation and Licensure.

7-003.05 Individual Provider Contracts: For an individual provider contract, MHCP Central Office staff must request -

1. A copy of the potential provider's professional resume and/or curriculum vitae; and/or
2. A copy of the certificate or other means of recognition.

Failure to provide this requested information within 120 days of the request disqualifies the potential provider for an MHCP contract. A new request must be submitted for MHCP to consider contracting with this provider.

Local office staff may be called upon to assist in recruitment of new medical providers by:

1. Making initial contact; and
2. Referral to Central Office to begin the contract process.

7-003.05A Professional Corporations: The Department must negotiate physician treatment service contracts only with individual physicians, not with a professional corporation.

7-003.05B Institutions Employing Physicians: The Department must negotiate contracts for treatment services only with the institution employing the physician\other professionals (usually medical schools), not with the individual employee.

7-003.05C Psychological Treatment Services: Psychological treatment services are provided only for clients eligible for major medical-burn services. The psychologist must -

1. Be selected by, or willing to work closely with, the MHCP-contracted physician providing burn services; and
2. Have, at a minimum, a doctorate degree in clinical psychology.

7-003.05D Audiology Treatment Services: A provider of audiology treatment services must be an audiologist with a masters or doctorate degree and licensed by the State of Nebraska.

7-003.05E Hearing Aid Providers: A hearing aid dealer/provider must be licensed as a provider of hearing aids in the State of Nebraska.

7-003.05F Clinic Consultant Contracts: MHCP does not require a separate contract with a clinic consultant if a contract is made with a teaching institution regarding the payment rate and use of the employee's time.

When an employer allows an employee to provide clinic consultation services on his/her own time and to be paid directly by MHCP, the employee is considered an independent contractor and a written contract is required. See 467 NAC 7-006.

Exception: If MHCP contracts with a provider of a professional corporation for medical treatment services, another contract for clinic consultant services is not necessary.

7-003.05G Physical and Occupational Therapy: For clinic consultation services, physical and occupational therapists must -

1. Be licensed by the State of Nebraska to be a physical therapist/occupational therapist; and
2. Have one of the following for pediatric training:
    a. Master's degree or its equivalent received from an approved school in occupational therapy or physical therapy with the major emphasis on pediatric therapy and six months of subsequent provision of occupational therapy or physical therapy to pediatric patients under age 16 on at least 25 percent of a full-time employment basis, or its equivalent; or

b. One year of providing occupational therapy or physical therapy to pediatric patients under age 16 on at least 25 percent of a full-time employment basis or its equivalent, with participation in the clinical refresher courses and training programs designed to increase and maintain consistency and quality of clinic teams and/or designed to maintain or increase competence in providing pediatric therapy as sponsored and/or as certified by MHCP, while maintaining a current (current is defined as "within a three-month time period") caseload of providing occupational therapy or physical therapy to pediatric patients at 25 percent of a full-time employment basis or its equivalent.

MHCP may contract with therapists who do not meet these criteria for pediatric clinics only when a therapist meeting these criteria is not available. These therapists will be paid at the lower rate listed in 467 NAC 7-009.14.

7-003.05H Clinic Nurse Coordinator: For the clinic nurse coordinator role at MHCP clinics a nurse must –

1. Be licensed by the State of Nebraska as a registered nurse;
2. Have a bachelor's degree in the field of nursing; and
3. Meet one of the following criteria for training and/or experience:
   a. One year experience in working as a nurse with children under age 16 with disabilities and/or children with chronic care needs; or
   b. Training as a pediatric nurse which includes working with children with disabilities and/or children with chronic care needs.

MHCP may contract with nurses who do not meet the bachelor's degree criteria if the training and/or experience is met and the MHCP medical consultant approves the contract.

MHCP may contract with nurses who do not meet the experience and/or training criteria. However, these nurses will be paid at 80% of the usual rate until they meet these criteria.

7-003.05J Nutritional Providers: For clinic consultation services and direct services to MHCP clients, a nutritionist must –

1. Be licensed by the State of Nebraska as a Licensed Medical Nutritional Therapist; and
2. Have a minimum of 30 contact hours of specific education and/or training in providing medical nutritional therapy to children with disabilities or chronic health needs as evidenced in the provider's professional resume and verified by educational transcripts and training course descriptions; or
3. Have a minimum of 20 hours of experience working with children under age 15 with disabilities or chronic medical conditions; or
4. Be grandfathered as an MHCP direct nutritional provider through prior experience as a member of an MHCP multidisciplinary team nutritional consultant.
5. Be grandfathered as an MHCP direct nutritional provider to children under age 15 with disabilities or chronic health needs by providing services to these children as a contracted Nebraska Medicaid provider prior to January 1, 2000. Exception: MHCP may contract with Licensed Medical Nutritional Therapists who do not meet these criteria for clients age 15 and younger when a therapists meeting these criteria is not available. These therapists will be paid at 80% of the usual rate until such time they meet these criteria; or

7-004 Specific Requirements for Participation: In addition to the general requirements for participation (see 467 NAC 7-002), a provider must meet the following specific requirements after a contract is signed.

7-004.01 Providers of Medical Treatment Services: A provider of medical treatment services must –

1. Bill for only the services approved and authorized by MHCP;
2. Perform consultation evaluations as requested by MHCP; and
3. Provide medical reports to MHCP stating the diagnosis, prognosis, and plan of treatment at no additional charge.

7-004.02 Providers of Surgical Treatment Services: Physicians contracted to provide surgical treatment services must -

1. Provide MHCP-covered surgeries in MHCP-contracted medical facilities;
2. Use an MHCP-contracted assistant when a surgical assistant is necessary;
3. Provide post-operative care as part of the surgical fee; and
4. Provide MHCP with reports of the surgical procedure at no additional charge to MHCP.

7-004.03 Providers of Psychological Treatment Services: Psychological treatment services are provided only for clients eligible for major medical-burn services. The psychologist must provide regular reports regarding the client's progress to MHCP at no additional charge.

7-004.04 Providers of Audiology Treatment Services: The audiologist must provide complete reports to MHCP at no additional charge, including reports of an audiogram, diagnostic information, recommended treatment plan, and general impressions.

7-004.05 Hearing Aid Providers: Each hearing aid dealer must -

1. Include charges for the following items as part of the sale price:
   a. The hearing aid(s);
   b. The ear mold satisfactorily fitted to the client;
   c. Cord and receiver, if required for a specific model of hearing aid;
   d. Warranty for mechanical defects;
   e. One year's reasonable service; and
   f. One month supply of batteries;
2. Provide insurance for up to three years at an additional cost;
3. Meet with a client up to three times during the first 90 days of the use of the aid for no additional charge;
4. Submit a bill only after the hearing aid is properly fitted and satisfactory to the client (Note: This is an exception to the 60-day requirement);
5. Refund the purchase price less $100 if an MHCP-contracted audiologist determines that the aid is not suitable for the client's needs;
6. Agree that any changes in brand, model, or modifications will be approved by a separately contracted MHCP audiologist who is not a member of or employee of the provider's hearing aid business or firm;
7. Contact the client's MHCP services coordinator if any repairs or services in excess of $250 are required; and
8. Directly supervise any employee who has a temporary license.

7-004.06 Providers of Dental Services: A provider of routine and/or specialized dental treatment must -

1. Follow the treatment plan outlined by the MHCP clinic team for each client;
2. Obtain specific prior authorization from the MHCP services coordinator before carrying out the recommendations of an MHCP clinic team; and
3. Contact the MHCP services coordinator for authorization if any deviation from the plan recommended by the MHCP clinic team is necessary. The MHCP services coordinator must contact MHCP Central Office staff for review and approval of any deviations from the plan.

7-004.07 Hospitals: A hospital must -

1. Obtain prior authorization of all services from MHCP;
2. Contact MHCP as soon as feasible in emergency situations; and
3. Provide medical reports to MHCP at no additional charge.

7-005 Contracts for Clinic Consultants: MHCP contracts with medical and paramedical personnel and institutions to provide consultation services at MHCP-sponsored clinics. In addition to the general regulations for MHCP provider contracts (see 467 NAC 7-003), each self-employed consultant must agree that s/he -

1. Is a self-employed independent contractor;
2. Is paid on an amount per child basis to be calculated on the number of children usually scheduled for the clinic;
3. Must attend the MHCP-sponsored clinic to receive payment for the clinic. Exception: The consultant will be paid if MHCP cancels a clinic without notifying the consultant at least five working days before the scheduled date of the clinic;
4. Will be paid state employee rates according to Department of Health and Human Services policies for travel and other expenses necessary for clinic attendance;
5. Will not be reimbursed for other travel arrangements when MHCP arranges and pays for travel and other expenses necessary for clinic attendance;
6. Will not be paid for clinics canceled due to inclement weather or other circumstances beyond MHCP's control;
7. Must dictate on-site the results of the examinations of the children scheduled for the clinic and other diagnostic/treatment planning recommendations;
8. Will subcontract only when approved by MHCP; and
9. Must provide statistical reports/information regarding clinic participation and the request of MHCP.

MHCP may increase the number of children normally scheduled for the specific clinic by one on an emergency basis and decrease the number of children by two without prior notice to the consultant. MHCP Central Office staff must coordinate the scheduling of clinic with the consultant at his/her convenience to the extent that these clinics must be also coordinated with other independent consultants.

7-006 Approved Providers: MHCP does not require individual contracts with providers of durable medical equipment, orthopedic appliances (prosthetics and orthotics), prescription drugs, medical supplies, occupational therapy, physical therapy, ambulance services, or nonspecialized physicians, noncontracted general hospitals, hospitals providing occasional emergency care or occasional care outside Nebraska and other providers as necessary. These providers must agree to meet the requirements of 467 NAC 7-002 and 7-003.04 by signing page 2 of the computer generated authorization.

7-007 Authorizing Payment: Payment for all medical care and treatment covered by MHCP must be authorized by the MHCP services coordinator. All third party sources must be exhausted before the MHCP services coordinator authorizes MHCP payment. Note: Medicaid is considered a third party source.

7-007.01 Contracted Providers: Authorizations for services are issued by MHCP. The provider must enter the authorization number on each billing submitted to MHCP. The bill will be returned if the authorization number is not included.

7-007.02 Temporary Providers: On occasion, a family may be receiving services from a provider who is not contracted with the program. MHCP may pay for temporary services for those families by issuing page two of the computerized authorization form, which asks the temporary provider to accept MHCP payment as payment in full, and not charge families for any balance not covered by the program. The provider is asked to fill out the second page of the authorization, sign, and return it with the bill.

7-008 Billing Requirements: The provider must submit bills to MHCP which must include the following information: Remains and addressed in chapter 5, section 002.01(B) as modified

1. The provider name and federal ID number or Social Security number;
2. The client's name;
3. The date and place of service;
4. The amount of any insurance payments received for the service and/or denial of payment by insurance and a copy of Explanation of Benefit (EOB); and
5. The authorization number;
6. For physician services, dental services, and lab and x-ray services: the procedure code and description;
7. For drugs: the name of the drug, the quantity dispensed, the prescription number, and the amount charged; and
8. The original page two of the authorization when sent to the provider.

Providers must submit bills to MHCP within 60 days from the date of service. Providers must document the extenuating circumstances for bills submitted more than 60 days from the date of service.

7-008.01 Medical Reports: MHCP must receive the following medical reports for services provided before payment can be made:

1. For a hospitalization, the discharge summary;
2. For emergency room services, ER report;
3. For surgery, the hospital discharge summary; and
4. For a physician's office visit, a report of each visit.

7-008.02 Third Party Liability: MHCP providers must accept as payment in full the rate established by the Nebraska Department of Health and Human Services for MHCP after all other sources have been exhausted. MHCP providers must bill for insurance or other third party that may be liable for payment for medical services before billing MHCP. A third party is any individual, entity, or program that is or may be liable to pay for all or part of medical services received by an MHCP client. Remains in chapter 5, section 002.01(A) as modified

If the provider is participating in an insurance program or other third party coverage and is accepting assignment or otherwise accepting the insurance or other third party's payment as payment in full, the provider must not bill MHCP for any additional payment. MHCP must not make any additional payment to the provider for services covered by the third party source.

7-009 Payment Rates Remains in chapter 5, section 003 as modified (all rates remain in this section but have been modified—pharmacy rates remain the same and the others have been changed to "follow the Medicaid fee schedules".)

7-009.01 Inpatient Hospital Care: MHCP must not exceed the Nebraska Medical Assistance Program's (NMAP) (also known as Medicaid) rate for payment for hospital in-patient services. MHCP Central Office staff may negotiate for a lower rate.

7-009.02 Rehabilitation Care: MHCP Central Office staff must negotiate a rate.

7-009.03 Transitional Care: MHCP may cover post-hospital transitional care in an appropriate licensed facility for a maximum of 60 days. MHCP must not exceed the facility's NMAP rate. If the facility is not an NMAP provider, MHCP Central Office staff must negotiate a rate.

7-009.04 Physicians Services: MHCP pays for physicians services at the lower of:

1. The providers submitted charge; or
2. Up to 110% of the allowable amount by the Nebraska Medicaid Practitioners Fee Schedule.

7-009.05 Durable Medical Equipment and Medical Supplies: MHCP Central Office staff must negotiate rates for durable medical equipment and medical supplies.

7-009.06 Dental Services: MHCP pays for dental services at the lower of:

1. The providers submitted charge; or
2. Up to 110% of the allowable amount by the Nebraska Medicaid Practitioners Fee Schedule.