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NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

181 NAC 1

TITLE 181 SPECIAL HEALTH PROGRAMS

CHAPTER 1 NEBRASKA CHRONIC RENAL DISEASE PROGRAM

001. SCOPE AND AUTHORITY. These regulations implement the Nebraska Chronic Renal Disease Program established by Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 71-4901, 71-4903, and 71-4904.

002. DEFINITIONS. The definitions set out in Neb. Rev. Stat. §§ 71-4901 to 71-4904 and the following are adopted for this chapter.

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

002.02 CHRONIC KIDNEY DISEASE. The slow loss of kidney function over time. End-Stage Renal Disease (ESRD) is the final stage of chronic kidney disease.

002.03 CLIENT. An individual applying for or receiving assistance from the Nebraska Chronic Renal Disease Program.

002.04 COMPLETE APPLICATION. An initial application or renewal application which contains all of the required information and documentation, with attestation from the applicant to its truth and completeness.

002.05 DEPRIVED. An individual within two years of applying for assistance from the Program who has directly or indirectly given away or sold property for less than fair market value for the purpose of qualifying for assistance.

002.06 EXPLANATION OF BENEFITS. An insurance company's written explanation regarding a claim showing what it paid on a client's behalf. May also be called a remittance advice.

002.07 THIRD-PARTY. An entity responsible for, or otherwise under an obligation to provide, the payment of all or part of the cost of the care and treatment of a person with chronic kidney disease or chronic renal disease.

003. ELIGIBILITY AND APPLICATION. To be eligible for participation in the Chronic Renal Disease Program, an applicant must meet all statutory requirements and the following:

(A) Be diagnosed with chronic kidney disease or chronic renal disease;

- (B) Require dialysis to maintain or improve his or her condition. An individual who has received a kidney transplant must have been a client prior to receiving the transplant and must be within three years of receiving the transplant in order to be served;
- (C) Annual income must be at or below three-hundred (300) percent of the federal poverty level in order to participate. The income level is adjusted based on household size; and
- (D) Accept any Medicaid benefits for which the applicant may be eligible and benefits from any other programs, including any third-party payment, to the maximum extent possible.

003.01 APPLICATION. Clients must submit, through the staff at a licensed health clinic where the client receives dialysis, a complete application provided by the Department and the following:

- (A) Income-verifying and household information;
- (B) Insurance information;
- (C) Medical certification that verifies the individual requires dialysis to maintain or improve his or her condition; and
- (D) Documentation of:
  - (i) United States citizenship or alien status; and
  - (ii) Nebraska residency.

003.02 APPROVAL. An approved application establishes client eligibility for seven years, provided the client continues to meet the eligibility requirements in this chapter. The service start date for a client is the first day of the month in which the complete Department approved application is received by the Department. The service start date may be adjusted upon the discretion of the Department.

003.03 PROVISIONAL APPROVAL. The Chronic Renal Disease Program may assist clients on a provisional basis subject to the limitations noted in this chapter. Provisional services require additional documentation or explanation at the time of application and are provided for 12 (twelve) months or less after which the client must provide updated documentation to continue participation. Provisional services may be adjusted or discontinued at the discretion of the Department. Client situations which may qualify for provisional approval include:

- (A) Those who are recently out-of-work due to their chronic kidney disease or chronic renal disease diagnosis;
- (B) Those who are homeless;
- (C) Those who are awaiting determinations from other insurances; or
- (D) Those who are awaiting a disability determination due to their diagnosis.

003.04 DENIAL. When an individual does not meet the eligibility requirements in this chapter, the Department must send adequate notice to the individual stating the reason for the denial.

003.05 RE-APPLICATION. To re-apply after a denial, a new complete application is required.

003.06 PAYMENT. Payment for any services prior to the client's service start date shall not be authorized.

004. MAINTENANCE OF CLIENT ELIGIBILITY. The client, or the client's representative, is responsible for informing the Department, in writing, within thirty (30) days of the following changes:

- (A) When the client's annual income increases above three hundred (300) percent of the federal poverty level;
- (B) In the number of persons living in the home;
- (C) To the treatment status which includes whether or not the client is still receiving dialysis, has had a kidney transplant, or has died;
- (D) To the client's residency; or
- (E) To the client's home address and primary phone number.

004.01 RENEWAL APPLICATIONS. A complete application must be submitted for each active client every seven years calculated from the service start date stated in the client eligibility letter. The renewal application must be received by the Department within sixty (60) days of the service end date noted on the client eligibility letter and include the documentation required by this chapter for initial approval.

005. BENEFITS. Benefits are set out below.

005.01 COVERED SERVICES. The Department may assist in paying for the following services that are directly related to the care and treatment of chronic kidney disease or chronic renal disease:

- (A) Pharmaceutical products listed on the Chronic Renal Disease Program's Reimbursable Drug Formulary.
- (B) Dialysis procedures listed on the Chronic Renal Disease Program's Reimbursement Procedures for Dialysis Services. Procedures must be provided through a licensed health clinic as described in 175 Nebraska Administrative Code (NAC) 7.
- (C) All services must be prescribed by a licensed health care provider possessing appropriate specialized knowledge in the diagnosis and treatment of chronic kidney disease or chronic renal disease.

005.02 NON-COVERED SERVICES. The Department does not pay for the following:

- (A) Any service denied by Medicare, Medicaid or any other health insurance as not medically necessary for the client;
- (B) Any service related to the treatment of diabetes or other non-renal related conditions;  
or
- (C) Services which are investigative or experimental.

006. LIMITATIONS. The annual amount paid by the Department on behalf of any one client will not exceed one and a one half percent (1.5%) of the amount allocated to the Department to operate the Chronic Renal Disease Program by the Nebraska Legislature for that state fiscal year. This amount may be adjusted upon the discretion of the Department based on the availability of funds and the number of clients served by the Chronic Renal Disease Program. A client will be given adequate notice that he or she has met his or her annual Program allotment. Service costs not covered by the Program after all other available insurance resources have determined and paid their share are the responsibility of the client.

006.01 OUT-OF-STATE SERVICES. Only out-of-state dialysis service providers or pharmacies, within fifty (50) miles of the Nebraska border that have signed a Chronic Renal Disease Program Service Provider Enrollment Form, may receive payment from the

Department for providing covered services for a client subject to the limitations noted in this chapter.

006.02 PAYER OF LAST RESORT. The Chronic Renal Disease Program is a payer of last resort. Primary insurance providers, private, Medicaid or Medicare, must be invoiced first and have paid on a client's behalf before an invoice is sent to the Chronic Renal Disease Program for payment consideration.

006.03 TERMINATION. Clients are no longer eligible for participation in the Chronic Renal Disease Program under the following circumstances:

- (A) Clients who stop dialysis treatments will be terminated from participation twelve (12) months after the month in which the course of dialysis is terminated;
- (B) Clients who receive a kidney transplant and no longer require dialysis will be terminated from participation thirty-six (36) months after the month in which the kidney transplant is received;
- (C) If a client's annual income exceeds three-hundred (300) percent of the federal poverty level;
- (D) If the client moves out-of-state he or she is terminated from participation effective the date of the move;
- (E) If the client fails to provide updated income-verifying or insurance documentation within the time frame requested by the Department;
- (F) Misrepresentation on the part of a client;
- (G) Upon death;
- (H) If there have been no payments for pharmaceutical or dialysis services processed on a client's behalf in one year. The year is calculated from the start of each state fiscal year;
- (I) Failure to inform the Department of changes to the client status as required by this chapter; or
- (J) Failure to submit a renewal application when due.

007. PROVIDER REQUIREMENTS AND PAYMENTS. To participate in the Chronic Renal Disease Program, service providers must be licensed by the Department, or its equivalent in another state. Service providers must complete and sign the Chronic Renal Disease Program's Service Provider Enrollment Form prior to participation. Providers not meeting the standards set out in the Provider Enrollment Form are not eligible to receive payment for covered services.

007.01 PHARMACEUTICAL PAYMENT. Only pharmaceutical products listed on the Chronic Renal Disease Program's Reimbursable Drug Formulary are eligible for payment. Payments are made in accordance with the Provider Standards noted in the Chronic Renal Disease Program's Service Provider Enrollment Form and follow the Payment procedures outlined in this chapter. Invoicing procedures are outlined in the Chronic Renal Disease Program's Reimbursement Procedures for Pharmacies and may be adjusted upon the discretion of the Department.

007.02 PAYMENT DETERMINATION. The pharmaceutical payment amount is based on Nebraska Medicaid fee for service allowable cost. Any remaining cost after the Department has paid is the responsibility of the client. Payment is subject to the limitations in this chapter and is made on behalf of a client directly to the pharmacy.

007.03 DIALYSIS SERVICE PAYMENT. The Department pays up to fifty (50) percent of the client co-pay after all other insurances or third-party payers have paid their share. The payment percentage may be adjusted upon the discretion of the Department. The remaining dialysis service cost after the Chronic Renal Disease Program has paid is the responsibility of the client. Payments are made directly to the service provider in accordance with the Provider Standards in the Chronic Renal Disease Program Service Provider Enrollment Form and follow the Payment procedures outlined in this chapter. Invoicing procedures are outlined in the Chronic Renal Disease Program's Reimbursement Procedures for Dialysis Services and may be adjusted upon the discretion of the Department.

008. PAYMENT. Payment for pharmaceuticals and dialysis services must be approved by the Department. Claims may be approved for payment when all of the following conditions are met:

- (A) A Chronic Renal Disease Program Service Provider Enrollment Form is on file with the Department for the entity claiming payment;
- (B) The client was approved for participation when the service was provided;
- (C) The services provided are covered services as described in this chapter; and
- (D) No more than six months have elapsed from the date of service until when the claim is received by the Chronic Renal Disease Program. Payment may be made by the Department for claims received more than six months after the date of service if the circumstances which delayed the submittal were beyond the provider's control. The Department may determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

008.01 PROVIDER'S FAILURE TO COOPERATE IN SECURING THIRD-PARTY PAYMENT. The Department shall deny payment of a provider's claims if the provider fails to apply third-party payments to covered services, file necessary claims, or cooperate in matters necessary to secure payment by insurance or other responsible third-parties.

008.02 THIRD-PARTY REFUNDS. Whenever a service provider receives a third-party payment after a claim has been paid by the Department, the provider shall refund the Department for the full amount of the payment. The refund must be accompanied by a copy of the documentation, such as the Explanation of Benefits or electronic coordination of benefits.

009. RIGHT TO A FAIR HEARING. The fair hearing process is conducted in accordance with 184 NAC 1. If a client is denied services, has his or her case terminated or believes the Department acted erroneously, the client may request a fair hearing. The request must be in writing and filed with the Department within (30) days of the mailing date on the written notice from the Department. The request must:

- (A) Include a brief summary of the Department's action being challenged;
- (B) Describe the reason for the challenge; and
- (C) Be sent to the Director of the Nebraska Department of Health & Human Services, Division of Public Health.