TITLE 181 SPECIAL HEALTH PROGRAMS

CHAPTER 1 NEBRASKA CHRONIC RENAL DISEASE PROGRAM

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

1-002 DEFINITIONS:

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

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

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

Department means the Nebraska Department of Health and Human Services.

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

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

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

1-003 CLIENT ELIGIBILITY AND APPLICATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1-004 MAINTENANCE OF CLIENT ELIGIBILITY

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

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

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

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

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

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

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

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

1-005 BENEFITS

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

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

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

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

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

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

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

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

1-005.03D Services which are investigative or experimental.

1-006 LIMITATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

1-006.04F Upon death.

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

1-007 PROVIDER REQUIREMENTS AND PAYMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1-008 APPROVAL AND PAYMENT

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

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

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

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

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

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

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

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

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

1-009 RIGHT TO A FAIR HEARING

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

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

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