TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 1 ADMINISTRATION

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 to 68-991.

002. NEBRASKA MEDICAID-COVERABLE SERVICES. Medicaid covers the services included and outlined in each service specific chapter in Nebraska Administrative Code (NAC) Titles 471, 473, 480, and 482. Each service must be medically necessary and appropriate, in accordance with this chapter, and any additional medical necessity requirements imposed by each service specific chapter in Title 471 NAC.

002.01 NEBRASKA MEDICAID MANAGED CARE PROGRAM. Each Managed Care Organization (MCO) provides behavioral health, physical health, and pharmacy services to eligible enrolled Medicaid clients. The Dental Benefits Manager is a Pre-Paid Ambulatory Health Plan (PAHP) that provides dental services to eligible enrolled Medicaid clients. Medicaid operates Managed Care in accordance with Title 482 NAC.

002.01(A) BENEFITS. The Heritage Health plan is required to provide the services in the core benefits package as defined in 482 NAC 4, in the amount, duration, and scope as described in this chapter. The Managed Care Organizations (MCOs) and Pre-Paid Ambulatory Health Plan (PAHP) can place appropriate limits on covered services consistent with medical necessity or based on utilization control.

002.01(B) PRIOR AUTHORIZATION, BILLING, AND PAYMENT. Services provided to clients enrolled in Managed Care are not billed to Medicaid. The provider will provide services only under an arrangement with the Managed Care Organization (MCO) or Pre-Paid Ambulatory Health Plan (PAHP), and the Managed Care Organization (MCO) or Pre-Paid Ambulatory Health Plan (PAHP) will make timely payment in accordance with 482 NAC 4. The prior authorization requirements, payment limitations, and billing instructions outlined in Title 471 NAC do not apply to services provided to clients enrolled in Managed Care unless otherwise stated in this chapter.

002.02 GENERAL REQUIREMENTS FOR ALL SERVICES. Providers must be enrolled in Medicaid for the service provided, ordered, referred, or rendered to be coverable.

002.02(A) MEDICAL NECESSITY. Services and supplies which do not meet the definition of medical necessity are not covered. For purposes of Medicaid fee-for-service and

Managed Care, medical necessity is health care services and supplies which are medically appropriate and:

(i) Necessary to meet the basic health needs of the client;
(ii) Rendered in the most cost-efficient manner;
(iii) Rendered in a type of setting appropriate for the delivery of the covered service;
(iv) Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
(v) Consistent with the diagnosis of the condition;
(vi) Required for means other than convenience of the client or the physician;
(vii) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; and
(viii) Relative to the goal of improved patient health outcomes.

002.02(B) PLACE OF SERVICE. Covered services in fee-for-service and Managed Care must be provided at the least expensive appropriate place of service. As deemed appropriate by Medicaid, payment for services provided at alternate places of service may either be denied, or reduced to what would have been payable at the least expensive appropriate place of service.

002.02(C) EXPERIMENTAL OR INVESTIGATIONAL. Medicaid in fee-for-service and Managed Care does not cover medical services which are considered investigational or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, payment for these services are prohibited.

002.02(C)(i) RELATED SERVICES. Medicaid does not pay for associated or adjunctive services that are directly related to non-covered experimental or investigational services.

002.02(C)(ii) INVESTIGATIONAL OR EXPERIMENTAL CRITERIA. Services are deemed investigational or experimental by the Department. The Department may convene ad hoc advisory groups of experts to review requests for coverage. A service is deemed investigational or experimental if it meets any one of the following criteria:

(1) The Food and Drug Administration (FDA), or other regulatory authority, has not approved the service or treatment for general marketing to the public for the proposed use;
(2) Reliable evidence does not lead to the conclusion that there is a consensus within the medical community that the service is a generally accepted standard of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease and age group. Also, facility specific data, including short and long term outcomes, must be submitted to the Department;

(3) The service is available only through an Institutional Review Board (IRB) research protocol for the proposed use or subject to such an Institutional Review Board (IRB) process; or
(4) The service is the subject of an ongoing clinical trial that meets the definition of a Phase I, Phase II, or Phase III Clinical Trial, regardless of whether the trial is actually subject to Food and Drug Administration (FDA) oversight and regardless of whether an Institutional Review Board (IRB) process is required at any one particular institution.

002.02(C)(iii) DEFINITION OF CLINICAL TRIALS. For services not subject to Food and Drug Administration (FDA) approval, the following definitions apply:
(1) Phase I: Initial introduction of an investigational service into humans;
(2) Phase II: Controlled clinical studies conducted to evaluate the effectiveness and safety of the service being investigated; and
(3) Phase III: Clinical studies to further evaluate the effectiveness and safety of a service that is needed to determine the overall risk and benefit and to provide an adequate basis for determining patient selection criteria for the service as the recommended standard of care. These studies usually compare the new service to the current recommended standard of care.

002.02(D) FAMILY PLANNING SERVICES. Medicaid in fee-for-service and Managed Care covers family planning services, including consultation and procedures, when requested by the client. Family planning services and information must be provided to clients without regard to age, sex, or marital status, and must include medical, social, and educational services. The client must be allowed to exercise freedom of choice in choosing a method of family planning. Family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician or registered nurse.

002.02(D)(i) COVERED SERVICES. Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

002.02(E) SERVICES PROVIDED OUTSIDE NEBRASKA. Payment in fee-for-service and Managed Care may be approved for services provided outside Nebraska in the following situations:
(1) When an emergency arises from accident or sudden illness while a client is visiting in another state and the client's health would be endangered if medical care is postponed until the client returns to Nebraska;
(2) When a client customarily obtains a medically necessary service in another state because the service is more accessible; and
(3) When the client requires a medically necessary service that is not available in Nebraska.

002.02(E)(i) PRIOR AUTHORIZATION REQUIREMENTS. Prior authorization in fee-for-service is required for services provided outside Nebraska when:
(1) The service is not available in Nebraska; or

(2) The service requires prior authorization under the applicable service specific chapter of Title 471 NAC.

002.02(E)(ii) PRIOR AUTHORIZATION PROCEDURES FOR OUT-OF-STATE SERVICES. In fee-for-service, the referring physician must submit request to the Department in written or electronic form. The request must include the following information or explanation as appropriate to the case:

(1) A summary evaluation by a licensed provider for the type of service rendered, and a statement indicating that the service is not available in Nebraska or is inadequate to meet the client's needs;
(2) The name, address, and telephone number of the out-of-state provider;
(3) An indication of whether the out-of-state provider is enrolled or is willing to enroll as a Nebraska Medicaid provider and accept the Medicaid allowable payment as payment in full for the services;
(4) A description of the client's condition. The physician must certify, based on a thorough evaluation, that the services being requested are medically necessary and not experimental or investigational;
(5) Identification of the physician who will be assuming follow-up care when the client returns to Nebraska;
(6) Any plan for follow-up and return visits, including a timeline for the visits and an explanation of the medical necessity for the return visits;
(7) If the client is requesting assistance with transportation, the type of transportation appropriate for the client's condition, and when ambulance, air ambulance, or commercial air transportation is being requested, the request must provide an explanation of medical necessity; and
(8) The client’s name, address, and Medicaid recipient identification number, or date of birth.

002.02(E)(iii) MANAGED CARE PROVIDERS. In Managed Care, the provider must provide services only under an arrangement with the Managed Care Organization (MCO).

002.02(F) SERVICES NOT DIRECTLY PROVIDED FOR TREATMENT OR DIAGNOSIS. Unless otherwise expressly allowed in Title 471, Medicaid in fee for service and Managed Care does not cover services provided to a client that are not directly related to diagnosis or treatment of the client’s condition.

002.02(G) SERVICES REQUIRED TO TREAT COMPLICATIONS OR CONDITIONS RESULTING FROM NON-COVERED SERVICES. Medicaid in fee-for-service and Managed Care may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services. Coverage of complication or conditions resulting from non-covered services will be determined at the discretion of the Department.

If the services in question are determined to be part of a previous non-covered service, that is, an extension or a periodic segment of a non-covered service or follow-up care associated with it, the subsequent services will be denied.

002.02(H) DRUG REBATES. Medicaid covers prescribed drugs only if the labeler has signed a Rebate Participation Agreement with the Secretary of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

002.02(H)(i) REBATE DISPUTE RESOLUTION. In any quarter, if a manufacturer discovers a discrepancy in Medicaid utilization information that the manufacturer and the Department are unable to resolve in good faith, the manufacturer must provide written notice of the discrepancy by National Drug Code (NDC) number to the Department within 30 days of receipt of the quarterly drug rebate invoice which contains the Medicaid utilization information.

002.02(H)(i)(1) MANUFACTURER DISPUTE. If the manufacturer, in good faith, believes that the Medicaid utilization information is erroneous, the manufacturer must pay the Department that portion of the rebate amount claimed that is not disputed within 30 days after receiving the Medicaid utilization information. Following resolution of the dispute, the balance due, if any, plus a reasonable rate of interest as set forth in Section 1903(d)(5) of the Social Security Act must be paid or credited by the manufacturer or by the Department by the due date of the next quarterly payment.

002.02(H)(i)(2) WRITTEN REQUEST. The Department and the manufacturer must use their best efforts to resolve the discrepancy within 60 days of receipt of notification. If the Department and the manufacturer are not able to resolve a discrepancy within 60 days, the manufacturer may file a written request for an administrative hearing under 465 NAC 6.

002.02(H)(i)(2)(a) HEARING DECISION. The hearing decision is not binding on the Secretary of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), for purposes of their authority to implement a civil money penalty provision in accordance with the statute or rebate agreement.

002.02(H)(i)(3) PAYMENT ADJUSTMENTS. Adjustments to rebate payments must be made if information indicates that either Medicaid utilization information, average manufacturer price (AMP), or best price is greater or less than the amount previously specified.

002.02(H)(ii) MANUFACTURER RIGHT TO APPEAL. Every manufacturer of a rebatable drug that has a signed rebate agreement has the limited right to appeal to the Medicaid Director for a hearing. This appeal right is limited to any discrepancies in the quarterly Medicaid utilization information only. No other matter relating to that manufacturer's drugs may be appealed to the Director.

002.02(H)(ii)(1) HEARING REQUEST. A manufacturer must request a hearing within 90 days of the date the Department gives notice to the manufacturer of the availability of the hearing process for the disputed drugs.

002.02(H)(ii)(2) HEARING PROCEDURES. Hearings are scheduled and conducted according to 465 NAC 6.

002.02(H)(iii) SUPPLEMENTAL DRUG REBATES. In addition to the requirements for drug rebates as described in this chapter. Medicaid may negotiate and contract for supplemental rebates with labelers of prescribed drugs. The negotiations and contracts may be between the labeler and the Department or an entity under contract with the Department to negotiate these supplemental rebates, including a single or multi-state drug purchasing pool. Any entity under contract with the Department will be fee based, and there will be no financial incentives or bonuses based on inclusion or exclusion of medications from the Preferred Drug List.

002.02(I) REQUIREMENTS FOR WRITTEN PRESCRIPTIONS. Medicaid in fee-for-service and Managed Care will not pay for written prescriptions for prescribed drugs unless executed on a tamper-resistant pad as required by federal law.

002.02(I)(i) EXCLUSIONS. The following prescriptions and other items are not required to be written on tamper-resistant prescription pads:

(1) Orders for drugs provided in Nursing Facilities, Intermediate Care Facility for clients with Developmental Disabilities (ICF/DD) facilities, and other specified institutional and clinical settings for which the drug is not separately reimbursed, but is reimbursed as part of a total service including:
    (a) Inpatient and outpatient hospital;
    (b) Hospice;
    (c) Dental;
    (d) Laboratory;
    (e) X-ray; and
    (f) Renal dialysis;
(2) Faxed prescriptions;
(3) Telephoned, or otherwise orally transmitted prescriptions; and
(4) E-prescribed, when the prescription is transmitted electronically.

002.02(I)(ii) REQUIREMENTS. A written Medicaid prescription must contain at least one of the three following characteristics:

(1) An industry-recognized feature designed to prevent unauthorized copying of a completed or blank prescription form, such as a high security watermark on the reverse side of the blank or thermochromic ink;
(2) An industry-recognized feature designed to prevent erasure or modification of information written on the prescription by the prescriber, such as tamper-resistant background ink that shows erasures or attempts to change written information; or
(3) An industry-recognized feature designed to prevent the use of counterfeit prescription forms, such as sequentially numbered blanks or duplicate or triplicate blanks.

002.02(I)(iii) EMERGENCY FILLS. Medicaid will pay for emergency fills for prescriptions written on non-tamper resistant pads only when the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written

on a non-compliant paper. The pharmacy must document the call on the face of the written prescription.

002.02 (J) MANAGED CARE CLIENTS. Clients participating in the Managed Care plans and Dental Benefits Manager are required to access services through their primary care provider.

003. FEDERAL AND STATE REQUIREMENTS. The Department is required by federal and state law to meet certain provisions in the administration of Medicaid.

003.01 MEDICAL ASSISTANCE ADVISORY COMMITTEE. The Medicaid Director will appoint an advisory committee to advise the Director in the development of health and medical care services policies. Members of the committee include: physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; members of consumers' groups, including Medicaid clients; and consumer organizations, such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; the Director of Public Health and the Chief Executive Officer of Health and Human Services. Members are appointed on a rotating basis to provide continuity of membership.

003.02 UTILIZATION REVIEW. Any individual or entity must provide the Department with any documentation or information requested as part of the Department's utilization review.

004. TELEHEALTH SERVICES FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES. This section applies to medical services in Medicaid fee-for-service and Managed Care.

004.01 DEFINITIONS. The following definitions apply to this section:

004.01(A) CHILD. An individual under 19 years of age.

004.01(B) COMPARABLE SERVICE. A service provided face-to-face.

004.01(C) DISTANT SITE. The location of the provider of the telehealth service.

004.01(D) ORIGINATING SITE. The location of the client at the time of the telehealth consultation.

004.01(E) TELEHEALTH CONSULATION. Any contact between a client and a health care practitioner relating to the health care diagnosis or treatment of such client through telehealth. For the purposes of telehealth services, a consultation includes any service delivered through telehealth.

004.01(F) TELEMONITORING. The remote monitoring of a client's vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care practitioner for analysis and storage.

004.02 APPLICABLE LAWS. Health care practitioners providing telehealth services must follow all applicable state and federal laws and regulations governing their practice and the services they provide.

004.03 ORIGINATING SITES. Health care practitioners must ensure that the originating sites meet the standards for telehealth services. Originating sites must provide a place where the client's right to receive confidential and private services is protected.

004.04 INFORMED CONSENT. Before an initial telehealth consultation, the health care practitioner must provide the client the following written information which must be acknowledged by the client in writing or via email:

(A) Alternative options are available, including in-person services. These alternatives are specifically listed on the client's informed consent statement;

(B) All existing laws and protections for services received in-person also apply to telehealth, including:

(i) Confidentiality of information;

(ii) Access to medical records; and

(iii) Dissemination of client identifiable information;

(C) Whether the telehealth consultation will be or will not be recorded;

(D) The identification of all the parties who will be present at each telehealth consultation, and a statement indicating that the client has the right to exclude anyone from either the originating or the distant site; and

(E) The written consent form becomes a part of the client's medical record and a copy must be provided to the client or the client's authorized representative.

004.05 BEHAVIORAL HEALTH SERVICES FOR CHILDREN. For each client who is a child who is receiving telehealth behavioral health services, the following protections must be in place:

(A) An appropriately trained staff member or employee familiar with the child's treatment plan or familiar with the child must be immediately available in person to the child receiving a telehealth behavioral consultation in order to attend to any urgent situation or emergency that may occur during provision of such service. This requirement may be waived by the child's parent or legal guardian. The medical record must document the waiver; and

(B) In cases in which there is a threat that the child may harm himself or herself or others, before an initial telehealth consultation the health practitioner must work with the child and his or her parent or guardian to develop a safety plan. Such plan must document actions the child, the health care practitioner, and the parent or guardian will take in the event of an emergency or urgent situation occurring during or after the telehealth consultation. Such plan may include having a staff member or employee familiar with the child's treatment plan immediately available in person to the child if such measures are deemed necessary by the team developing the safety plan.

004.06 TELECOMMUNICATIONS TECHNOLOGY COSTS. Telehealth services and transmission costs are covered by Medicaid when:

(1) The technology used meets industry standards;

(2) The technology is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant; and

(3) The telehealth technology solution in use at both the originating and the distant site must be sufficient to allow the health care practitioner to appropriately complete the service billed to Medicaid.

004.06(A) STANDARDS. The standards above apply to any peripheral diagnostic scope or device used during the telehealth consultation.

004.06(B) COVERAGE. Coverage is available for teleradiology services when the services meet the American College of Radiology standards for teleradiology.

004.07 TELEMONITORING REIMBURSEMENT. Medicaid will reimburse for telemonitoring when all of the following requirements are met:

(1) The services are from the originating site;
(2) The client is cognitively capable to operate the equipment or has a willing and able person to assist in the transmission of electronic data;
(3) The originating site has space for all program equipment and full transmission capability; and
(4) The provider must maintain a client's record containing data supporting the medical necessity of the service, all transmissions and subsequent review received from the client, and how the data transmitted from the client is being utilized in the continuous development and implementation of the client's plan of care.

004.07(A) PER DIEM RATE. Telemonitoring is paid at a daily per diem rate set by Medicaid and includes the following:

(i) Health care practitioner review and interpretation of the client data;
(ii) Equipment and all supplies, accessories, and services necessary for proper functioning and effective use of the equipment;
(iii) Medically necessary visits to the home by a health care practitioner; and
(iv) Training on the use of equipment and completion of necessary records.

004.07(B) FIXED PAYMENT. No additional or separate payment beyond the fixed payment is allowable.

004.08 PRACITIONER CONSULTATION REIMBURSEMENT. Medicaid will reimburse a consulting health care practitioner when all of the following requirements are met:

(1) After obtaining and analyzing the transmitted information, the consulting health care practitioner reports back to the referring health care practitioner;
(2) The consulting health care practitioner must bill for services using the appropriate modifier; and
(3) Payment is not made to the referring health care practitioner who sends the medical documentation.

004.08(A) EXCLUSIONS. Practitioner consultation is not covered for behavioral health services when the client has an urgent psychiatric condition requiring immediate attention by a licensed mental health practitioner.

004.09 REIMBURSEMENT OF TELEHEALTH. Telehealth services are reimbursed by Medicaid at the same rate as the service when it is delivered in person in accordance with each service specific chapter in Title 471 NAC.

004.10 REIMBURSEMENT OF ORIGINATION SITE FEE. The originating site fee is paid to the Medicaid-enrolled facility hosting the client for telehealth services at a rate set forth in the Medicaid fee schedule or under arrangement with the Managed Care Organization (MCO).

004.11 OUT-OF-STATE TELEHEALTH SERVICES. Out-of-State telehealth services are covered if the telehealth services otherwise meet the regulatory requirements for payment for services provided outside Nebraska and:

(A) When the distant site is located in another state and the originating site is located in Nebraska; or

(B) When the Nebraska client is located at an originating site in another state, whether or not the provider's distant site is located in or out of Nebraska.

004.12 DOCUMENTATION. The medical record for telehealth services must follow all applicable statutes and regulations on documentation. The use of telehealth technology must be documented in the same medical record, and must include the following telehealth information:

(A) Documentation of which site initiated the call;

(B) Documentation of the telecommunication technology utilized; and

(C) The time the service began and ended.

005. CLIENT RESTRICTED SERVICES PROGRAM. This section applies to medical services in Medicaid fee-for-service and Managed Care.

005.01 RESTRICTED SERVICES CRITERIA. The Department may restrict a client to obtain Medicaid services only from a designated provider, or renew a period of restricted services, when the client has used Medicaid services at a frequency or amount that is not medically necessary. When evaluating whether a client has used services at a frequency or amount that is not medically necessary, the Department may consider any of the following criteria:

(A) Number, type, or dosage of prescriptions obtained by the client;

(B) Number of prescribers prescribing medication to the client;

(C) Number of pharmacies dispensing to a client;

(D) Number of clinic or emergency room encounters; or

(E) Whether the client displays at-risk behavior, as exhibited by any of the following:

(i) A client with a medical history of seeking and obtaining health care services at a frequency or amount that is not medically necessary; or

(ii) Behaviors or practices that could jeopardize a client's medical treatment or health including, but not limited to:

(1) Forging or altering prescriptions;

(2) Noncompliance with medical or drug and alcohol treatment;

(3) Paying cash for medical services that result in a controlled substance prescription or paying cash for controlled substances;

(4) Arrests for diversion of controlled substance prescriptions;

(5) Positive urine drug screen for illicit drugs or non-prescribed controlled substances;

(6) Negative urine drug screen for prescribed controlled substances; or

(7) Use of a client's Medicaid card for an unauthorized purpose.

005.02 DESIGNATION OF RESTRICTED SERVICES PROVIDER(S). The Department will designate a provider to provide services to a client placed into restrictive services. A designated provider must be located within a reasonable distance of, and must be reasonably accessible to, the client.

005.02(A) DURATION OF RESTRICTED SERVICES. A client placed into restricted services must obtain Medicaid services from the designated provider for a period of no more than 12 months. Upon the expiration of a period of restricted services, the Department may renew such period based upon the Department's review of the client's pattern of utilization.

005.02(B) DURATION OF PROVIDER DESIGNATION. A client placed in restricted services must remain with the designated provider, unless any of the following occur:

(i) The designated provider is no longer located within a reasonable distance of, or is no longer reasonably accessible to, the client;
(ii) The designated provider refuses to continue to serve the client;
(iii) The designated provider is no longer enrolled in Medicaid; or
(iv) A change is requested by the client and approved by the Department. A client may request a change of the designated provider no later than 90 days after a designation is made. Such request must be made to the Department in writing.

005.03 SERVICES BY PROVIDERS NOT LISTED AS RESTRICTED SERVICES PROVIDERS. Claims for services provided to a restricted services client by other than the designated provider will not be approved, with the following exceptions:

(A) Emergency care is defined as medically necessary services provided to a client who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions;
(B) A primary care provider may refer a restricted services client to a non-designated provider for a specified length of time. Any referral made by a primary care provider to a non-designated provider must be approved by the Department prior to the non-designated provider providing services to the client. Referrals are not required for the following:
    (i) Non-emergent medical transportation;
    (ii) Home and community based services;
    (iii) Mental health and substance abuse services;
    (iv) Routine eye exams;
    (v) Radiology services;
    (vi) Laboratory services;
    (vii) Family planning;
    (viii) Obstetrics provider services only;
    (ix) Dialysis; and
    (x) Nursing home services; and
(C) Prescriptions will be covered if prescribed or authorized by a primary care provider, or within the setting of a hospital for non-emergency care if approved by a primary care provider.

005.04 RESTRICTED SERVICES NOTIFICATION. The client will be provided notice of the client's placement into restrictive services no fewer than 10 days before restricted services are imposed.

005.04(A) CLIENT APPEAL RIGHTS. A client may appeal the Department's decision to place the client into restricted services. Any appeal must be submitted in writing no later than 90 days after the client is placed into restricted services. If an appeal is submitted within 10 days after notice of the client's placement into restrictive services is mailed, the effective date of the restricted services will be stayed until the appeal has been decided.

005.04(B) CHANGE IN DESIGNATED PROVIDER. A client may appeal the Department's decision to deny the client's request to change a designated provider. Any appeal must be submitted in writing no later than 90 days after the Department's decision.

005.05 PHARMACY CLAIMS. Pharmacy claims submitted for prescriptions dispensed to a client in the restricted services program by providers other than a designated provider will not be paid except in a medical emergency. A pharmacy submitting a claim must provide documents indicating a medical emergency existed at the time the prescription was dispensed.

006. ADVANCE DIRECTIVES. An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under applicable law that relates to the provision of medical care if the client becomes incapacitated. Medicaid-participating hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, and Managed Care Organizations (MCOs) must:

(A) Maintain written policies, procedures, and materials concerning advance directives;
(B) Provide written information to all adult clients receiving medical care by or through the provider or organization concerning their rights under applicable law to:
  (1) Make decisions concerning their medical care;
  (2) Accept or refuse medical or surgical treatment; and
  (3) Formulate advance directives, such as living wills or durable power of attorney for health care; and
(C) Provide written information to all adult clients on the provider's policies concerning implementation of these rights;
(D) Document in the client's medical record whether the client has executed an advance directive;
(E) Not condition the provision of care or otherwise discriminate against a client based on whether that client has executed an advance directive;
(F) Ensure compliance with requirements of applicable law concerning advance directives; and
(G) Provide for educating staff and the community on advance directives.

006.01 WHEN PROVIDERS GIVE INFORMATION CONCERING ADVANCE DIRECTIVES. Providers must give information concerning advance directives to each adult client as follows:

(A) A hospital must give information at the time of the client's admission as an inpatient;
(B) A nursing facility must give information at the time of the client's admission as a resident;

(C) A provider of home health care or personal care services must give information to the client in advance of the client's coming under the care of the provider;
(D) A hospice program must give information at the time of initial receipt of hospice care by the client; and
(E) A Managed Care Organization (MCO) must give information at the time of enrollment. If a managed care plan has more than one medical record for its members, it must document in all medical records.

006.02 INFORMATION CONCERING ADVANCE DIRECTIVES AT THE TIME AN INCAPACITATED CLIENT IS ADMITTED. A client could be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether the client has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated client in accordance with applicable law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once the client is no longer incapacitated.

006.03 PREVIOUSLY EXECUTED ADVANCE DIRECTIVES. When the client or a relative, surrogate, or other concerned or related client presents the facility with a copy of the client's advance directive, the facility must comply with the advance directive to the extent allowed under applicable law. This does not preclude a facility from objecting as a matter of conscience, if it is permitted to do so under applicable law.

006.04 INFORMATION CONCERNING ADVANCE DIRECTIVES ABSENT CONTRARY LAW. Absent contrary applicable law, if no one comes forward with a previously executed advance directive and the client is incapacitated or otherwise unable to receive information or articulate whether the client has executed an advance directive, the facility will note that the client was not able to receive information and was unable to communicate whether an advance direct.