

EFFECTIVE
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NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

482 NAC 7

TITLE 482 NEBRASKA MEDICAID MANAGED CARE

CHAPTER 7 RIGHTS AND RESPONSIBILITIES

001. SCOPE AND AUTHORITY. This chapter sets forth responsibilities of the health plans, Dental Benefits Manager, and providers of services to ensure the member is fully informed, in writing and verbally, of their rights and responsibilities as well as avenues for pursuing complaints and grievances. Similarly, providers participating in the health plan networks are entitled to the same processes as any Medicaid-enrolled provider according to Title 471 Nebraska Administrative Code (NAC).

002. RIGHTS AND RESPONSIBILITIES. The following rights and responsibilities apply to a member participating in Heritage Health. The health plans have the requirement to inform the member, in writing and verbally, regarding their rights and responsibilities. No person may be subjected to discrimination in any Departmental program or activity based on their race, color, sex, age, national origin, religious creed, political beliefs, or disability.

002.01 MEMBER RIGHTS. The member has the right to:

- (A) Be treated with respect, dignity, and without discrimination or retaliation;
- (B) Be given information about their illness, or medical condition; understand the treatment options, risks and benefits; and make an informed decision about whether they will receive treatment;
- (C) Participate in decisions about their healthcare including the right to refuse treatment;
- (D) Talk with their doctor and health plan and know their medical information will be kept confidential;
- (E) Choose their health plan and primary care physician provider;
- (F) Have access to their health plan and primary care provider;
- (G) Receive medical care in a timely manner;
- (H) Request a copy of their medical record and request changes to their medical record;
- (I) Make a complaint about the provider or health plan, and receive a timely response;
- (J) Receive information on the medical services provided by their health plan;
- (K) Change their primary care provider at any time;
- (L) Change their health plan within 90 days of initial enrollment or every 12 months without cause thereafter;
- (M) Have Heritage Health and health plan materials explained or interpreted;
- (N) Have interpreters at no cost, if necessary, during medical appointments and in all discussions with their primary care provider or health plan;
- (O) Request an appeal if services are denied, terminated, or reduced;
- (P) Make advance directives, if desired, and receive assistance if needed; and
- (Q) Receive proper medical care twenty-four (24) hours a day, seven (7) days a week.

002.02 MEMBER RESPONSIBILITIES. The member has the responsibility to:

- (A) Understand, to the best of his or her ability, how Heritage Health is used to receive health care;
- (B) Choose a primary care provider within the health plan's network;
- (C) Take their Medicaid ID card and health plan ID card to all medical appointments and to the pharmacy for prescriptions;
- (D) Keep their scheduled appointments;
- (E) Call their doctor's provider's office at least 24 hours in advance if their appointment must be rescheduled;
- (F) Tell their doctor about any medical problems;
- (G) Ask questions about things they do not understand;
- (H) Follow the provider's orders and advice;
- (I) Assist with the transfer of their medical records;
- (J) Receive services from their primary care provider unless referred elsewhere by their primary care provider; and
- (K) Cooperate with all Heritage Health inquiries and surveys.

002.03 PROVIDER RIGHTS AND RESPONSIBILITIES. Providers participating in Heritage Health or Dental Benefits Manager have the same rights and responsibilities as any Medicaid enrolled provider pursuant to Title 471 NAC.

003. GRIEVANCE PROCESS. The health plan or dental benefits manager must inform the member, in writing, of the grievance process for issuing a complaint involving access to care, quality of care, or communication issues with the plan or primary care provider. The member, or legal representative, must file the grievance with the health plan or dental benefits manager, according to the same plans' internal grievance procedure, pursuant to 1931(b)(4) of the Social Security Act.

- (A) A member may file a grievance either orally or in writing;
- (B) A provider may file a grievance when acting as the client's authorized representative;
- (C) The health plan must resolve each grievance and provide notice, as expeditiously as the member's health condition requires, not to exceed 90 days from the day the plan receives the grievance;
- (D) The plan must provide notice of the grievance resolution in writing in a language and format which is easily understood by the member. The plan must make reasonable effort to notify the member orally of the grievance resolution; and
- (E) All contacts with the health plan regarding grievances must be documented and submitted to the Department.

004. APPEALS PROCESS. The Heritage Health plan or Dental Benefits Manager must notify the member in writing of the appeals process for challenging any adverse benefit determinations. The member, or the provider on behalf of the member, may request an appeal with the Heritage Health plan or Dental Benefits Manager, request a State fair hearing, or both.

004.01. AVENUES FOR REQUESTING AN APPEAL. The member, or the provider with the member's written consent on behalf of the member, has the following avenues for requesting an appeal:

- (A) File a Heritage Health plan or Dental Benefits Manager Level Appeal: The member may contact verbally or in writing the Heritage Health plan or Dental Benefits Manager

to request a hearing and following that Heritage Health plan's or Dental Benefits Manager's internal appeal process. The request for appeal must be within sixty (60) days from the date on the notice of adverse benefit determination. An appeal filed orally must be followed by a written, signed appeal; or

- (B) Request a State Fair Hearing: A member may request a State fair hearing only after the member has exhausted the Heritage Health plans or Dental Benefits Manager's internal appeal process. The member must submit in writing to the DHHS Legal and Regulatory Services within one hundred twenty (120) days from the date of the Heritage Health plan's or Dental Benefits Manager's notice of resolution. Hearings are scheduled and conducted according to the procedures outlined in 465 NAC.

004.02 NOTICE OF ADVERSE BENEFIT DETERMINATION. The Heritage Health plan or Dental Benefits Manager must notify the requesting provider, and give the member written notice of any adverse benefit determination. The notice must be in writing and be a language and format that is easily understandable to the member. The notice to the provider need not be in writing.

004.02(A) TIMEFRAMES FOR NOTICE OF ADVERSE BENEFIT DETERMINATION.

The following are timeframes for notice of adverse benefit determination:

- (i) Denial of Payment: The Heritage Health plan or Dental Benefits Manager must give notice on the date of adverse benefit determination when the adverse benefit determination is a denial of payment.
- (ii) Standard Service Authorization Denial: Notice must be given as expeditiously as the member's health condition requires not to exceed fourteen (14) calendar days following the receipt of the request for service. The timeframe may be extended up to fourteen (14) additional calendar days if the member or provider requests the extension or if the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and demonstrates that the delay is in the member's interest. If the timeframe is extended, the member must be provided written notice of the reason for the decision to extend the timeframe and right to file a grievance if he or she disagrees with that decision. The determination must be issued and carried out as expeditiously as the member health condition requires and no later than the date the extension expires.
- (iii) Termination, Suspension, or Reduction of Services: Notice must be given at least ten (10) days before the date of adverse benefit determination when the adverse benefit determination is a termination, suspension, or reduction of a previously authorized Medicaid-covered service. The period of advance notice is shortened to five (5) days if probable fraud has been verified. Notice by the date of the adverse benefit determination must be given by the date of the adverse benefit determination for the following circumstances:
 - (1) Death of the member;
 - (2) A signed written member statement requesting service termination or giving information requiring termination or reduction of services (where the member understands that this adverse benefit determination must be the result of supplying that information);
 - (3) The member's admission to an institution where the member is ineligible for further services;

- (4) The member's address is unknown and mail directed to him or her has no forwarding address;
 - (5) The member has been accepted for Medicaid services by another jurisdiction;
 - (6) The member's physician or dentist prescribes the change in the level of medical care; or
 - (7) The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs.
- (iv) Expedited Service Authorization Denial: For cases in which a provider indicates or the Heritage Health plan or Dental Benefits Manager determines that following the standard timeframe could seriously jeopardize the member's life, or health, or ability to attain, maintain, or regain maximum function, an expedited authorization decision must be made and notice provided as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. This timeframe may be extended up to fourteen (14) additional calendar days if the member requests the extension or if the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and demonstrates that the delay is in the member's interest. If the timeframe is extended, the member must be provided written notice of the reason for the decision to extend the timeframe and right to file a grievance if they disagree with that decision. The determination must be issued and carried out as expeditiously as the member's health condition requires and no later than the date the extension expires.
- (v) Untimely Service Authorization Decision: Notice must be provided on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse benefit determinations.

004.03 RESOLUTION AND NOTIFICATION. The Heritage Health plan or Dental Benefits Manager must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, not to exceed thirty (30) days from the day the appeal is received. This timeframe may be extended up to fourteen (14) calendar days if the member requests an extension or the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and how the delay is in the member's interest. For any extension not requested by the member, notice of the reason for delay must be provided to the member.

004.03(A) WRITTEN NOTICE OF RESOLUTION. Written notice of resolution of the appeal must be provided to the member. The written resolution must include:

- (i) Results and date of the appeal resolution; and
- (ii) For decisions not wholly in the member's favor:
 - (1) The right to request a state fair hearing for decisions not wholly in the member's favor;
 - (2) How to request a State fair hearing;
 - (3) The right to receive benefits pending a hearing;
 - (4) How to request the continuation of benefits; and

- (5) If the appeal decision is upheld, that the member may be liable for the cost of continued benefits received while the appeal was pending.

004.04 CONTINUATION OF BENEFITS. The member may have his or her benefits continue while an appeal is pending.

004.04(A) REQUIREMENTS FOR CONTINUATION OF BENEFITS. The Heritage Health plan or Dental Benefits Manager must continue member benefits if all of the following apply:

- (i) The appeal is filed timely, meaning on or before the later of the following:
 - (1) Ten (10) calendar days of the Heritage Health plan or Dental Benefits Manager mailing of the notice of adverse benefit determination; or
 - (2) The intended effective date of the proposed adverse benefit determination;
- (ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- (iii) The services were ordered by an authorized provider;
- (iv) The authorization period has not expired; and
- (v) The member requests a continuation of benefits.

004.04(B) REQUIREMENTS FOR ENDING CONTINUED BENEFITS. If the member's benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

- (i) The member withdraws the appeal;
- (ii) The member does not request a fair hearing and continuation of benefits within ten (10) calendar days from when the Heritage Health plan or Dental Benefits Manager mails the notice of adverse resolution to the member's appeal;
- (iii) A state fair hearing decision adverse to the member is made; or
- (iv) The authorization expires or authorization service limits are met.

004.04(C) RECOVERY OF COSTS DURING CONTINUATION OF BENEFITS. The Heritage Health plan or Dental Benefits Manager may recover the cost of the continuation of benefits furnished to the member while the appeal was pending if the final resolution of the appeal upholds the Heritage Health plan's or Dental Benefits Manager's adverse benefit determination.

004.04(D) PAYMENT OF COSTS DURING CONTINUATION OF BENEFITS. The Heritage Health plan or Dental Benefits Manager must pay for disputed services if the Heritage Health plan or Dental Benefits Manager or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

004.05 EXPEDITED APPEALS PROCESS. The Heritage Health plan or Dental Benefits Manager must conduct an expedited review process when the Heritage Health plan or Dental Benefits Manager determines, for a request from the member, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations. The Heritage Health plan or Dental Benefits Manager must not

take punitive action against a provider who either requests an expedited appeal or supports a member's appeal.

004.05(A) REQUESTING AN EXPEDITED APPEAL. The member or provider may file an expedited appeal either orally or in writing. No additional member follow-up is required.

004.05(B) TIMEFRAMES FOR EXPEDITED APPEALS. The Heritage Health plan or Dental Benefits Manager must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than seventy-two (72) hours after the Heritage Health plan or Dental Benefits Manager received the appeal. This timeframe may be extended by up to fourteen (14) calendar days if the member requests the extension or if the Heritage Health plan or Dental Benefits Manager shows that there is need for additional information and demonstrates that the delay is in the member's interest. For any extension not requested by the member, written notice of the reason for delay must be provided to the member.

004.05(C) TIMEFRAMES FOR PROVIDING EVIDENCE AND ALLEGATIONS. The Heritage Health plan or Dental Benefits Manager must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing.

004.05(D) DENIAL OF AN EXPEDITED APPEAL. If the Heritage Health plan or Dental Benefits Manager denies a request for an expedited resolution of an appeal, the Heritage Health plan or Dental Benefits Manager must:

- (i) Transfer the appeal to the standard timeframe of no longer than thirty (30) days from the day the Heritage Health plan or Dental Benefits Manager receives the appeal; and
- (ii) Make reasonable effort to give the member prompt oral notice of the denial and a written notice within two (2) calendar days.

004.05(E) NOTIFICATION OF APPEAL RESOLUTION. The Heritage Health plan or Dental Benefits Manager must provide written notice of the appeal resolution. In addition to written notice, reasonable effort must be made to provide oral notice of resolution.

005. CULTURAL SENSITIVITY AND DIVERSITY. The Department is a culturally diverse environment that exercises zero tolerance of any acts of discrimination, racism, or prejudice. Understanding, valuing, and promoting cultural sensitivity and diversity is part of the ongoing philosophy of the Department and any of its programs. Heritage Health and the Dental Benefits Manager is required to promote this philosophy with the member, providers, and within the workplace.

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005.01 USE OF MEMBER INFORMATION. The Heritage Health plan and Dental Benefits Manager will receive information on the member's race, ethnicity, and primary language from the eligibility file transmitted to the plans by the Department or the enrollment broker. The Heritage Health plans and Dental Benefits Manager is expected to use this information to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.