CHAPTER 3-000 PAYMENT FOR MEDICAID SERVICES

3-001 Definitions:

Claim means a request for payment for services rendered or supplied by a provider to a client.

Clearinghouse means an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction and receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard or nonstandard data content for the receiving entity.

HCPCS means the Healthcare Common Procedure Coding System. This contains the national codes adopted by the federal Secretary of Health and Human Services and includes American Medical Association's Current Procedural Terminology (CPT) Level I procedure codes and Level 2 procedure codes.

Indian means an individual, defined at 25 U.S.C. sections 1603(c), 1603(f), and 1679(b), or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

Indian Health Care Provider means a health care program, including contract health services, operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined 25 U.S.C. 1603.

Standard Transaction means an electronic transaction that complies with the applicable standard adopted under federal law.

Transaction means the exchange of information between two parties to carry out financial or administrative activities related to health care.

Trading Partner Agreement (TPA) means an agreement related to the electronic exchange of information.

Warrant means a paper check or electronic funds transfer.

3-002 Approval and Payment

3-002.01 Approval: Payment for medical care and services through ~~NMAP~~ Medicaid funds must be approved by the Department. Claims will be approved for payment when all of the following conditions are met:

1. A provider agreement is on file with the Department, as well as the certification and transmittal from the state licensing agency or the Centers for Medicare and Medicaid Services (CMS) Regional Office when required;
2. The client was eligible for ~~NMAP~~ Medicaid when the service was provided, or the service was provided during the period of retroactive eligibility;
3. No more than ~~**12 months**~~ 6 months have elapsed from the date of service when the claim is received by the Department (see 471 NAC 3-002.01A for exceptions);

4. The medical care and services are within the guidelines of ~~NMAP~~ Medicaid;
5. The client's case record must contain information to meet state requirements; and
6. A trading partner agreement has been approved, if required, for clearinghouses, billing agents, and providers submitting claims using electronic transactions.

3-002.01A Exceptions: Payment may be made by the Department for claims received more than ~~**12 months**~~ 6 months after the date of service ~~only~~ if the circumstances which delayed the submittal were beyond the provider's control. Some circumstances that are considered by the Department to be beyond the provider's control include, but are not limited to -

1. Provider's eligibility;
2. Client's retroactive eligibility;
3. Client's failure to submit appropriate information;
4. Unusual Central Office delay; or
5. Third party casualty situations (see 471 NAC 3-004.06C).

The Department shall determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

Payment may be made by the Department for claims that are received within one year after the date of service for Medicaid-approved special education services provided by school districts, as authorized by Neb. Rev. Stat. § 43-2511.

3-002.01B Timely Payment of Claims: The Department shall pay claims within 12 months of the date of receipt of the claim. This time limitation does not apply to -

1. Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system;
2. Claims which have been filed in a timely manner for payment by Medicare, for which the Department may pay a Medicaid claim relating to the same services. Claims for the Medicaid portion must be submitted to the Department within six months from the date of the Medicare remittance advice;
3. Claims from providers under investigation for alleged fraud or abuse;
4. Payments made -
   a. In accordance with a court order;
   b. To carry out hearing decisions or agency corrective actions taken to resolve a dispute;
   c. To extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it; or
5. Third party casualty situations as specified in 471 NAC 3-004.06C.

3-002.01C Denial: The Department shall not pay claims received more than two years after the date of service, except under the circumstances specified in 471 NAC 3-002.01B or 3-004.06B.