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 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 Medicaid when the service was provided, or the service was provided during the period of retroactive eligibility;
3. No more than 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 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 6 months after the date of service 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.

3-002.01D Provider's Failure to Cooperate in Securing Third Party Payment: The Department may deny payment of a provider's claims if the provider fails to apply third party payments to medical bills, to file necessary claims, or to cooperate in matters necessary to secure payment by insurance or other liable third parties.

3-002.02 Payment

3-002.02A Upper Limits: The Department has established upper limits for payment as described in each provider chapter.

3-002.02B Coverage Exception: Certain medical services, while being medically necessary, may exceed the NMAP coverage guidelines which have been established by the Department. Under these circumstances, the determination of medical necessity for payment purposes is based upon the professional judgment of the Department's consultants and other appropriate staff.

3-002.02C Payment in Full: Providers participating in NMAP shall agree to accept as payment in full the amount paid according to the Department's payment methodologies after all other sources have been exhausted.

Exception: If a client resides in a nursing facility, a payment to the facility for the client to occupy a single room is not considered income in the client's budget if Medicaid is or will be paying any part of the nursing facility care.

3-002.02D Charges to the General Public: Providers shall not exceed their charges to the general public when billing NMAP. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to Medicaid clients who would otherwise qualify for the discount.

3-002.02E Method of Payment: Effective January 1, 2009, payment for all approved medical services within the scope of NMAP will be made by electronic funds transfer (EFT) to the provider who supplied the services.

3-002.02F Billed Charges: If the provider's billed charges are less than the Department's allowable payment, the Department pays the provider's billed charges.

Exception: Inpatient hospital services are paid on a diagnosis-related group (DRG) or per diem basis, regardless of billed charges.

3-002.03 Post-Payment Review: Payment for a service does not indicate compliance with NMAP policy. Monitoring may be accomplished by post-payment review to verify that NMAP policy has been followed. A refund will be requested if post-payment review finds that NMAP payment has been made for claims/services not in compliance with NMAP policy. During a post-payment review, claims submitted for payment may be subjected to further review or not processed pending the outcome of the review.

3-002.04 Payment for Medical Expenses: Payment may not be made from NMAP funds for medical expenses which have been paid from county funds or other public or private sources.

3-002.05 Excess Income/Share of Cost: Individuals who are otherwise eligible but who have excess income shall obligate the excess amount for medical care before payment for medical services can be approved through NMAP. Obligation or payment of the excess amount is documented on Form DSS-160, "Record of Health Cost-Share of Cost-Medicaid Program" (see 471-000-79). For further information, the provider may contact the client's local office.

3-002.06 Inquiry on Status of Claims: For questions regarding claim status, providers may contact Department staff as directed in the claim submission instructions in the appendix to this Title or the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277) (see standard Electronic Transaction Instructions at 471-000-50). Providers may direct questions regarding regulations to the Medicaid Division.

3-002.07 Adjustments to Payment Reductions or Disallowances: Providers are restricted to a maximum time limitation of 90 days to request an adjustment to a claim that has been paid with a portion reduced or disallowed, or a claim that has been disallowed in total, unless documentation of extenuating circumstances is submitted to the Medicaid Division. The 90-day limitation begins with the payment date of the paper remittance advice (Form MCP-248) or with the payment date of the electronic remittance advice (ASC X12N 835).

3-002.08 Refunds

3-002.08A Refunds Requested by the Department: When the Department requests a refund of all or part of a paid claim, the provider is allowed 30 days to refund the amount requested, to show that the refund has already been made, or to document why the refund request is in error or appeal. The provider's failure to respond within 30 days shall be cause for the Department to recoup from future provider payments until the situation is resolved or to sanction the provider. The refund request shall constitute notice of the sanction to recoup from future payments. For refunds due to third party resources, see 471 NAC 3-004.10.

Note: NE-POP providers may be requested to void claims through the NE-POP system instead of submitting checks.

3-002.08B Third Party Liability Refunds: Whenever third party liability payments are received after a claim has been submitted to the Department, the provider shall refund the Department within 30 days. The refund must be accompanied by a copy of the documentation, such as the explanation of benefits or electronic coordination of benefits.

3-002.08C Provider Refunds to the Department: Providers have the responsibility to review all payments to ensure that no overpayments have been received. The provider shall refund all overpayments to the Department within 30 days of identifying the overpayment.

3-002.09 Claim Reports: These claim reports are issued weekly.

3-002.09A Remittance Advice: Remittance advice for payment of approved services is issued electronically using the standard Health Care Claim Payment/Advice transaction (ASC X12N 835) or on paper with Form MCP248 Remittance Advice (see 471-000-85).

3-002.09B Refund Request: A request for refund is issued electronically or on paper with Form MCP248 Refund Request.

3-002.09C Rejected Claims, Deleted Claims, and Denied Adjustments: Rejected claims, deleted claims, and denied adjustments are reported on Form MCP524, Electronic Claims Activities Report.

3-002.10 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. At any time fraud or abuse is suspected.

A provider has no right to a hearing on a finding by the Director that a reopening or correction of a determination or decision is not warranted.

3-002.11 Billing the Client: Providers participating in NMAP agree to accept NMAP's payment as payment in full. The provider shall not bill the client for Medicaid coverable services if the claim is denied by the Department for lack of medical necessity or for failure to follow a procedural requirement (such as prior authorization, claim submission instructions, timely claims filing limits, etc.). The provider shall not

bill the client for services covered by NMAP. It is not a violation of NMAP's regulations for the provider to bill the client for services not covered by NMAP. It is not a violation for a provider to bill the client for services when it is determined that the client has received money from a third party resource and that money was designated to pay medical bills. See 471 NAC 3-004.10B, 3-004.05, and 3-004.05F.

If the client agrees in advance in writing to pay for the non-covered service, the provider may bill the client.

The provider has the responsibility to verify the client's eligibility for Medicaid and any limitations, such as lock-in or managed care, that apply to a specific client. It is the provider's responsibility to be aware of requirements for medical necessity, prior authorization, referral management, etc.

3-002.12 Section 1122 Sanctions: When the Department of Health and Human Services imposes a sanction under section 1122 of the Social Security Act and instructs the Department to withhold or recoup the federal share of the capital expenditure, the Department shall withhold the federal and the state share of the capital expenditure.

3-002.13 Disclosure of Information: See 465 NAC 2-005.02.

3-003 Billing Requirements

3-003.01 Claims Submission: Providers shall submit claims for payment for medical services on the appropriate Medicaid billing forms attached and incorporated into these rules or the appropriate ASC X12N health care claim format for electronic transactions.

3-003.01A Institutional Services: Claims for the following services must be submitted by using the paper Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49.):

1. Ambulatory Room & Board;
2. Assisted Living Facilities;
3. Dialysis;
4. Home Health;
5. Rural Health Clinic;
6. Hospital;
7. Hospital-Based Ambulance;
8. ICF/MR's; and
9. Nursing Facilities*.

* Form MC-4, Long Term Care Turnaround may be used for nursing facility services instead of Form CMS-1450.

3-003.01B Practitioner Services: Claims for the following services must be submitted by using the paper Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (see Claim Submission Table at 471-000-49.):

1. Ambulatory Surgical Center;
2. Durable Medical Equipment and Supplies;
3. Federally Qualified Health Center;
4. Licensed Practitioner (to submit claims for Dental services, see 471 NAC 3-003.01D);
5. Medical Transportation*;
6. Non-Hospital-Based Ambulance;
7. Non-Rural Health Clinic;
8. Personal Care Aide**; and
9. Private Duty Nursing***.

* Form MS-65 must be used for paper submission of claims for Medical Transportation Services (see 471-000-63). Form MS-66 must be used for paper submission of claims for mental health transportation services.

** Form MC-82 must be used for paper submission of claims for Personal Care Aide Services (see 471-000-60).

*** Form MC-82N must be used for paper submission of claims for Private Duty Nursing services (see 471-000-59).

*** Form MC-82-AD must be used for paper submission of claims for private duty nursing or personal care aide services provided in adult day care centers.

3-003.01C Retail Pharmacy Services: Claims must be submitted electronically via the Nebraska Point of Purchase (NE POP) system, using the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard transaction.

3-003.01D Dental Services: Claims must be submitted by paper using the American Dental Association (ADA) Dental Claim Form or the standard electronic Health Care Claim: Dental Transaction (ASC X12N 837). For instructions on claim submission, see the Claim Submission Table in the appendix at 471-000-49.

3-003.02 Claim Certification: The submission of the claim form by the provider, the provider's authorized representative, or the provider's billing agent on behalf of an approved provider certifies that:

1. The services were medically indicated and necessary to the health of the patient, and were personally rendered by the provider, or under the provider's direction;
2. The services were provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973;
3. The amounts claimed are in compliance with the Department's policies, and no additional charge has been or will be made;
4. The information on the claim is true, accurate, and complete;
5. Each service is documented in the provider's files, and documentation is available to the Department, the federal Department of HHS, and state and federal fraud and abuse units; and

6. The provider understands that payment and resolution of this claim will be made from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

3-003.02A Paper Submission: The provider, the provider's authorized representative, or the provider's billing agent on behalf of an approved provider must sign the paper Medicaid billing forms that contain signature fields. Computer generated signatures are accepted and must be the signature of the service rendering provider, not the clinic or corporation. When a computer-encoded document is used as the Medicaid billing mechanism, the Department may request the provider's source input document from the provider for input verification and signature requirements. The signature constitutes certification as required by 471 NAC 3-003.02.

3-003.02B Electronic Submission: The submission of any electronic claim by the provider, the provider's authorization representative, or the provider's billing agent on behalf of an approved provider constitutes certification as required by 471 NAC 3-003.02.

3-003.03 Claims for Prolonged Care: When medical care is required for a prolonged period, such as nursing home care, extended hospital care, home health agency care, or other continuous service, the Department recommends that the provider submit claims for payment at intervals of not less than one month, so that payment may be kept current.

3-003.04 Electronic Claims and Computer-Encoded Claim Documentation: The provider shall allow the authorized representatives of the federal Department of HHS, the Department, and state and federal fraud and abuse units to review and audit the provider's or the provider's billing agent's or clearinghouse's data processing procedures and supportive software documentation involved in the production of the computer-encoded claims or electronic claims submitted to the Department. The provider has agreed to allow the Department and its authorized representatives access to its records under the provider agreement.

3-004 Third Party Resources (TPR): All third party resources available to a Medicaid client must be utilized for all or part of their medical costs before Medicaid. Third party resources (TPR) are any individual, entity, or program that is, or may be, contractually or legally liable to pay all or part of the cost of any medical services furnished to a client. Third party resources include, but are not limited to -

1. Private health insurance;
2. Casualty insurance, including medical payment provisions;
3. Employment-related group health insurance;
4. Group health plans defined under section 607(1) of ERISA;
5. Medicare Part A and/or Part B;
6. Medicare Part C (Medicare Advantage plans);
7. Medicare Part D;
8. Medical support from non-custodial parents (court or administrative ordered) (see 471 NAC 3-004.08);
9. Excess income/share of cost (see 471 NAC 3-001.05);
10. Workers' compensation;
11. Other federal programs (unless excluded by statute, such as Indian Health Services programs and Migrant Health programs, and Title V, Maternal Child Health Program);
12. Liable third parties who are not insurance carriers;
13. Medical payments provisions of automobile and commercial insurance policies; and
14. Any other party contractually or legally liable to pay medical expenses.

The Nebraska Chronic Renal Disease Program and the Medically Handicapped Children's Program are not included as TPR. Medicaid payment is made only after all third party resources have been exhausted or met their legal contractual or legal obligations to pay. Medicaid is the payor of last resort.

3-004.01 Definitions: The Nebraska Medical Assistance Program (NMAP) uses the following definitions in relation to third party resources:

Adjudicate: To determine whether a claim or adjustment is to be paid or denied.

Balance Billing: Billing NMAP or client for remaining amount left after a provider has agreed to accept a lesser amount from the primary payor as payment in full. Balance billing is prohibited.

Casualty Insurer: An insurance policy that pays for medical care as a result of an accident, incident, injury, disability, or disease; for example, automobile insurance, homeowners insurance, commercial liability insurance, product liability insurance, workers compensation, etc.

Client Assignment of Rights: The client's action to assign to the Department his/her rights (and the rights of any other eligible individuals on whose behalf s/he has legal authority under state law to assign such rights) to medical support and to payment for medical care from any third party resource (except Part A and B of Medicare). Assignment of rights is accomplished by signing the Medicaid application.

Commercial/Cost-Share Copayment: Fixed payment amounts, as determined by the insurer (including Medicare Advantage plans), that an individual must pay to access services.

Cost Avoidance: A method of adjudicating claims as payor of last resort in order to utilize all third party resources before Medicaid payment can be made.

Denial: Non-payment of benefits by a third party resource. See 471 NAC 3-004.06D1.

Excess Income/Share of Cost: The amount of the client's income that must be obligated or paid for medical care before Medicaid payment can be made.

Health Insurer: Any group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act (ERISA) of 1974 (amended in 1993), an entity offering a service benefit plan, or a health maintenance organization (HMO).

HMO Plan: Health Maintenance Organization - A type of managed care health plan that provides health care in return for a fixed payment from a subscriber or their employer with medical care being restricted to network physicians and a referral being necessary to utilize providers outside the network.

Lien: A method for physicians, nurses, and hospitals to protect the value of medical services by filing legal notice of right to payment pursuant to Neb.Rev.Stat. Section 52-401.

Medical Support: The obligation of a non-custodial parent to provide health insurance and/or pay for medical care ordered by a court or administrative body established under state law.

Medicare Advantage Plan: Medicare C - Coordinated care plans that meet Medicare C (Medicare Advantage plan) standards, including health maintenance organizations (HMO) (with or without point of service options), Provider Sponsored Organizations (PSOs) and Preferred Providers Organizations (PPOs), religious fraternal benefits plans, and other coordinated care plans. Persons eligible for Medicare Part A and Part B may choose to enroll in a Medicare Advantage Plan instead of the traditional Medicare fee-for-service program. Part B only enrollees are ineligible.

Medicare/Medicaid: Persons dually eligible for Medicare and Medicaid during the same period of time.

Medicare Part A: A federal program, created by the Social Security Act of 1965, to provide coverage of hospital, skilled nursing and certain other services for Medicare beneficiaries.

Medicare Part B: A federal program, created by the Social Security Act of 1965, to provide coverage of practitioner, durable medical equipment, supplies and certain other services for Medicare beneficiaries.

Co-insurance: A dollar amount, usually expressed as a percentage, for a covered service that is not paid by the primary insurer, that is the financial responsibility of the client or other payer on behalf of the client. (For example, for Medicare Part B covered services, Medicare pays 80% of the Medicare allowable and the remaining 20% is the co-insurance amount).

Deductible: A dollar amount, other than a premium, that a client, or other payer on behalf of the client, must pay before any covered service is paid for by the insurer. (For example, the standard Medicare Part D deductible for calendar year 2006 is $250).

Coverage Gap: for Medicare Part D, the cost of Part D drugs for which there is no coverage, also known as the "doughnut hole". (For calendar year 2006, for beneficiaries that do not qualify for the low income subsidy, the coverage gap is $2,250 to $5,100 or $2,850).

Premium: The cost of purchasing insurance, Medicare or other health insurance coverage, which may be a monthly or annual dollar amount. (For example, the Medicare Part B premium for calendar year 2005 is $78.20 per month).

Medicare Part D: A federal program, also known as the Medicare prescription drug benefit, that was created by the Medicare Modernization Act of 2003 (P.L. 108-173). This voluntary program provides coverage of certain drugs, classes of drugs or therapeutic categories of drugs and certain medical supplies or equipment for all Medicare beneficiaries, including those beneficiaries that are also eligible for Medicaid (dual-eligibles). Clients who are dual eligibles are automatically enrolled in Part D.

Medicare Part D Plan: An entity, approved by the Centers for Medicare and Medicaid Services, to provide coverage of Medicare Part D drugs and certain medical supplies related to the administration of insulin for Medicare beneficiaries under the Medicare Modernization Act of 2003 (P.L. 108-173).

Medicare Part D Drug: Any drug, class of drugs or therapeutic category of drugs that is not a Medicare Part D Excluded drug (see definition of Medicare Part D Excluded drug below), regardless of formulary, prior approval or tiering status by the Part D Plan.

Medicare Part D Excluded Drug: Any drug, class of drugs or therapeutic category of drugs that is specifically excluded from coverage under the Medicare Modernization Act of 2003 (P.L. 108-173) and amendments to that act, and/or as defined by federal regulations implementing the Medicare Modernization Act (for example, cough and cold preparations).

Medicare Part D Covered Supplies or Equipment: Insulin syringes, needles, alcohol swabs, gauze and other products related to the administration of insulin that are covered by Medicare Part D Plans.

Non-Custodial Parent: Parent who does not reside with a child but has a legal responsibility to provide court or administrative ordered medical support for the child.

Pay and Chase: A recovery method in which Medicaid pays the total amount allowed under NMAP and then seeks to recover from liable third party resources.

Private Insurer: This includes -

1. Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-related and indemnity contracts);
2. Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis and treatment of an injury, disease, or disability; and
3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments for services, including self-insured and self-funded plans (under section 607(1) of ERISA).

PPO Plan: Preferred Provider Organization - Fee for service plan with an incentive to use network providers to provide care for the plan's subscribers. Patients may see physicians outside the network but at reduced payment rate. A copayment may be required on certain services.

PSO Plan: Provider Sponsored Organization - Public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial portion of health care items and services directly through providers or affiliated groups of providers. Affiliated providers share, directly or indirectly, substantial financial risk, and have at least a majority financial interest in the PSO.

Remittance Advice: The third party plan's statement of payment for services. When billing Medicaid, this statement may be provided as a paper or electronic remittance advice, and must include the following information: the insurance company name, patient name, dates of service, charges, and amount paid. If charges were denied by insurance, the portion of the remittance advice showing the denial reason must be included.

Subrogation: Right of the state to stand in place of the client in collection of third party resources.

3-004.02 Availability of Third Party Resource Information: The Coordination of Benefits/Third Party Liability (COB/TPL) Unit of the Department of Health and Human Services Finance and Support maintains all known current health insurance, casualty insurance, and/or Medicare coverage on the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124). Providers may also obtain this information using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). If the provider becomes aware of any additional third party resources, the provider shall contact the COB/TPL Unit and report the new sources.

3-004.02A Request for Release of Patient Account Information: To alert the Department to potential TPR, the provider shall notify the COB/TPL Unit if a provider receives a request for an itemized bill or a request for the balance of a bill from the client, an attorney, an insurance company, or employer. This does not include routine billing information requests to process insurance or Medicare. The provider may release the information in accordance with the provider's standard office practice.

3-004.03 Payor of Last Resort: Medicaid clients who have third party resources must exhaust these resources before Medicaid considers payment for any services. Medicaid shall not pay for medical services as a primary payor if a third party resource is contractually or legally obligated to pay for the service.

Providers shall bill all third party resources and/or the client (when there is an excess income/share of cost obligation) for services provided to the client, except for waiver claims (see 471 NAC 3-004.03A). Providers shall submit all charges and Medicare covered services provided to Medicare/Medicaid clients to Medicare plus any Medicare supplement plans for resolution prior to billing Medicaid. Medicaid is the payor of last resort.

3-004.03A Waiver Claims: Certain services, defined as "waiver claims," are an exception to the requirement of 471 NAC 3-004.03. Providers may submit these claims to Medicaid before filing for TPR; NMAP pays these claims and COB staff initiate recovery activities for any TPR. This does not prohibit the provider from billing the TPR before billing Medicaid. In these situations, the provider does not bill Medicaid until the claim is resolved.

Waiver claims, for health insurance purposes, are claims for which the Department has applied and received a "cost avoidance" waiver from CMS or claims that are mandated to have cost avoidance waived under 42 CFR 433.139 (preventive pediatrics, prenatal services, medical support from "uncooperative" non-custodial parents).

3-004.03B Services Not Covered by Medicare: NMAP may cover services within the scope of NMAP that are not covered by Medicare. NMAP shall not cover any Medicare Part D Drug or Medicare Part D covered supply or equipment even if coverage is denied by the Medicare Part D Plan. For services never covered by Medicare, documentation of the Medicare denial is not required. For NMAP covered services, refer to individual 471 NAC chapters.

3-004.03C Provider Practices: It is the provider's responsibility to protect the value of their services through the use of sound business practices. Providers can best protect themselves by adopting procedures which -

1. Seek assignment of proceeds of health insurance policies;
2. Seek assignment of the provider's rights to institute legal recovery of medical expenses; or
3. Place liens against the outcome of third party resources (Exception: Waiver claims or professionals unable to file liens).

3-004.04 Medicare Part A & B Deductible and Coinsurance: Medicaid pays the deductible and coinsurance for Medicare-covered services. The Department accepts Medicare's utilization review and payment decisions for Medicare allowable fees, except that after crediting any amount received from Medicare for Medicare-covered services and crediting any amount received from any third party resource (TPR), Medicaid will pay the lesser of the Medicare or Medicaid allowable amount of any remaining amount due. ~~The amount received from Medicare for Medicare-covered services and other third party resources (TPR) and/or Medicaid for deductible and/or coinsurance shall not exceed Medicare allowable amount. (See billing instructions 471-000-70.)~~

3-004.04A Medicare Part D Monthly Premium, Deductible, Co-Insurance and Coverage Gaps: Medicaid does not pay the premium, deductible, co-insurance or coverage gaps for Medicare Part D.

3-004.04B Medicare Part A Coinsurance for Nursing Facility Services: For nursing facility services covered under Medicare Part A, Medicaid payments are limited to rates and payments according to the following method:

1. If the Medicare payment amount for a claim exceeds or equals the Medicaid rate or payment for that claim, Medicaid reimbursement will be zero (0).

2. If the Medicaid rates and payments for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

   a. The difference between the Medicaid rates and payments minus the Medicare payment amount; or
   b. The Medicare coinsurance and deductible, if any, for the claim.

3-004.05 Provider Payment in Full: Medicaid payment is the lower of the provider's usual and customary charge or the Medicaid allowable less all third party payment. When a claim is submitted to Medicaid with a payment from a third party resource, the provider is considered paid in full when payment from the third parties and/or Medicaid equals or exceeds the Medicaid allowable amount. The provider may only bill the client for a Medicaid noncovered service, or Medicaid copayment fees, where applicable, or if the client has received payment from the TPR.

3-004.05A Medicare Part A & Part B: NMAP payment of Medicare coinsurance and deductible constitutes payment in full. The provider shall not balance bill.

3-004.05B Medicare Advantage: NMAP payment of Medicare Advantage coinsurance and deductible constitutes payment in full to the provider. The provider shall not balance bill.

3-004.05C Medicare Part D: NMAP does not pay premiums, deductible, co-insurance or coverage gaps for Medicare Part D.

3-004.05D Medicare Waiver of Liability: When a Medicare/Medicaid client signs a Medicare Waiver of Liability and Medicare denies the claim as "not reasonable and necessary," NMAP will not pay the claim.

3-004.05E Use of Contracts by Medicare/Medicaid Beneficiaries: If providers negotiate private contracts with Medicare/Medicaid beneficiaries for which no claim is to be submitted to Medicare and for which the provider receives no reimbursement from Medicare directly, neither Medicare nor Medicaid would cover the services provided under the private contract.

3-004.05F Casualty Settlements With a Third Party Resource: When a provider enters into an agreement with a Medicaid client or a representative of the client to accept less than billed charges, the provider is considered paid in full. No further payment is due from either the client or NMAP.

3-004.05G Provider's Failure to Cooperate in Securing Third Party Payment: The provider's failure to file necessary claims for TPR (except waiver claims) or to cooperate in securing payments by other third party resources are grounds for denial of the claims. If NMAP denies claims for these services, the client cannot be billed unless the payment went to the client.

3-004.06 Filing Claims with TPR

3-004.06A Waiver of Cooperation for Good Cause: With respect to obtaining medical care support and payments or identifying and providing information to assist the State in pursuing liable third parties for a child for whom the individual can legally assign rights, the Department must find that cooperation is not in the best interests of the individual or the person to whom Medicaid is being furnished because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person (see 466 NAC 1-006.04).

3-004.06B Timely Filing of Claims with Health Insurance: Providers shall first submit all claims to third party resources. To secure a provider's right to Medicaid consideration for payment, a claim must be filed within 12 months from service date even if the TPR has not been resolved. If the provider fails to submit a claim or fails to contact the COB Unit within 12 months from the date of service, NMAP will not pay the claim.

If the provider filed a claim with NMAP within 12 months of the date of service and received a Medicaid denial due to the existence of a third party resource, the provider is allowed up to 12 months from the original receipt date of the Medicaid claim to resolve the third party resource. The provider shall submit the claim to NMAP within six months of the date on the insurance or Medicare remittance advice no later than 12 months from the original receipt date of the Medicaid claim.

3-004.06C Timely Filing of Claims with Casualty Insurance: Providers must submit claims within 24 months of the date of service. In some casualty third party situations, the Department recognizes that it may take longer than 24 months to resolve the third party obligation. In these situations, the Department can make payment beyond the 24 months if the provider can document that action was taken to obtain payment from the third party. If a provider has received a denial from NMAP due to the existence of casualty insurance coverage and the provider has sought payment from the third party, then the provider can request the Department to reconsider payment if the provider has waited 24 months and the third party has not paid the provider. If the provider has filed a lien, then the provider shall release its lien upon receipt of payment from NMAP. These situations are reviewed on a case by case basis.

3-004.06D Filing Medicaid Claims After Resolving Third Party Resources: Providers shall bill NMAP only when all third party resources have failed to cover the service or when a portion of the cost of the service has been paid. The provider must submit the third party documentation (such as the remittance advice, letter of denial, letter from attorney, or copy of check) with each claim submitted to the Department. The dates of service on the third party documentation must match the dates of service on each claim.

When billing NMAP, the provider shall bill the usual and customary charge for each service. The provider shall not submit a claim showing only the Medicaid allowable amount or the difference between the Medicaid allowable amount and the amount of the third party payment.

If after the provider has submitted a claim with the third party resource documentation and NMAP has adjudicated the claim for payment and the provider wishes to request an adjustment, the provider must submit the adjustment request within 90 days from the payment date on the Remittance Advice.

3-004.06D1 TPR Denials

3-004.06D1a Health Insurance Denials: NMAP will recognize and consider payment on claims the health insurance has denied with a valid health insurance denial. A valid health insurance denial may include, but is not limited to, the following reasons:

1. Deductible was applied to dates of service on this claim;
2. Coverage was not in effect for this client on dates of service;
3. Client was never covered;
4. Annual or lifetime maximum allowable for the services has been exhausted during or prior to dates of service; or
5. Non-covered service based on policy exclusions.

3-004.06D1b Medicare Denials: NMAP will recognize and consider payment on claims Medicare has denied when the claim is submitted with a valid Medicare denial. A valid Medicare denial may include, but is not limited to, the following reasons:

1. Coverage was not in effect for this client on dates of service;
2. Client was never covered by Medicare;
3. Non-covered procedure; or
4. Item or service is never covered by Medicare.

NMAP may not consider payment for services that have been denied by Medicare for lack of medical necessity.

3-004.06D1c Casualty Insurance Denials: NMAP will recognize and consider payment on claims involving casualty coverage denial, when the claim is submitted with a valid casualty denial. A valid casualty insurance denial may include, but is not limited to, the following reasons:

1. Services not related to the incident;
2. Coverage not in effect; or
3. Coverage limits exhausted for all coverage types available and with all insurance carriers obligated.

The insurer's statement that payment cannot be made at this time due to a pending liability determination or litigation is not a valid denial. Information is provided on Form MCP 575, “Casualty Insurance Information Sheet.

3-004.06D2 Filing Electronic Claims with Third Party Resources: Medicaid will accept electronic claims when third party resources (health insurance and/or Medicare coverage) are available. The health insurance and/or Medicare documentation is required. (See 471-000-103.)

3-004.06D2a Automatic Transfer of Claims From Medicare: NMAP accepts Medicare crossover claims directly from Medicare's fiscal intermediaries and will pay the deductible and coinsurance when no additional third party resource is identified. Claims received from Medicare must include Medicare supplemental insurance coordination of benefits/remittance advice documentation, if applicable.

3-004.06E Third Party Resource Reversal of Payment to Provider: If a provider filed a claim with a third party resource and received payment in full, and thus did not bill Medicaid, and the third party resource reverses its determination after 12 months from the date of service, the provider may bill NMAP for the services. The provider shall bill NMAP within 60 days from the date on the third party reversal document and refund. The provider shall submit documentation of the reversal with the claim. The claim may be considered for payment by NMAP only if the date of service is no more than 24 months from the date of receipt of claim.

3-004.06F Prior Authorization and Third Party Resources: The provider shall resolve all third party resources before Medicaid can consider paying a claim even when Medicaid prior authorization has been given.

3-004.06G Client's Medicaid Eligibility and Third Party Resources: The provider shall resolve all third party resources before Medicaid can consider paying a claim even though the client is eligible for Medicaid. (Exception: Waiver claims - see 471 NAC 3-004.03A.) A client's eligibility for NMAP does not guarantee payment of a claim.

3-004.07 Long Term Care Insurance Policies: A long term care indemnity policy is considered a health insurance policy when the policy -

1. Allows assignment of benefits; and
2. Covers medical care based on specified criteria.

Long Term Care insurance which meets this criteria is not considered income for eligibility determination.

Because nursing facility claims are included in the category of "waiver claims," NMAP will pay these claims at the specific per diem for the client less any excess income/share of cost the client is obligated to pay the provider for the monthly services. The COB Unit will seek recovery on all of these policies. Because the claims have been paid, the provider shall not bill the insurer. The provider shall assist the COB Unit in obtaining reimbursement from these policies by furnishing any medical documentation the insurer requests.

A provider may choose to bill the long term care insurance; in these situations, the provider does not bill Medicaid.

If the provider or the client receives a payment directly from the insurer, the payment shall be sent to the COB/TPL Unit.

Whenever the Department receives any payments from long term care insurance which exceed what Medicaid has paid toward the care of the client, the Department shall apply the excess to any Medicaid expenditure for that Medicaid client even if the expenditure was not covered by the third party. The application of the excess TPL payment is not limited to a particular Medicaid service and can be applied to any claims for that Medicaid client paid by Medicaid. After the excess TPL payment has been applied to all claims, any remaining amount shall be paid to the client.

3-004.08 Medical Support from Non-Custodial Parents: When children with a non-custodial parent become Medicaid eligible, medical support is court ordered in compliance with Omnibus Budget Reconciliation Act 1993 (OBRA '93). The County Attorney's staff or Child Support Enforcement staff shall notify the COB/TPL Unit of any health insurance coverage and/or Medical Support Court Orders obtained for a child who is eligible for Medicaid. When a non-custodial parent is ordered by the court to furnish health insurance and/or make payment for medical services the provider may bill Medicaid for the services if the provider has not received payment from the health insurer or non-custodial parent within 30 days of the date of service. Medicaid shall pay the claims and the COB/TPL Unit shall seek recovery from the health insurer or non-custodial parent.

To determine whether a court order exists, the provider may contact the COB/TPL Unit. The provider is not required to continue to seek payment from the health insurer or non-custodial parent before billing Medicaid when there is court-ordered medical support.

Non-custodial parent medical support court orders may include an obligation by the non-custodial parent to pay a percentage of medical expenses after the health insurer has made payment. The provider is not required to seek payment from the non-custodial parent in these cases. If the provider receives a payment from a non-custodial parent, the provider shall indicate this amount and the amount received from the health insurer as a prior payment or amount paid on the claim submitted to Medicaid. The provider shall submit with the claim a copy of the documentation showing the non-custodial parent made the payment. If the provider receives payment from the non-custodial parent after Medicaid has paid the claim, the provider shall refund Medicaid according to 471 NAC 3-004.10A.

3-004.08A Health Insurer Obligation When Non-Custodial Parent Has Medical Support Court Order: A health insurer may not deny a child insurance coverage if the non-custodial parent has a court or administrative order for medical support. An insurer shall provide custodial parents information to file claims; allow the custodial parent or provider to file claims; and pay claims to the custodial parent, provider, or the Department, as required by Neb.Rev.Stat. Section 44-3,149. If the provider receives a denial of insurance coverage for any of these reasons from an insurer and the client is a child, the provider shall contact the COB/TPL Unit.

3-004.09 Provider Refunds to the Department: When a provider receives payment from a third party resource on a claim previously paid by NMAP, the provider shall submit a refund to the Department. The provider shall include the third party documentation, such as a remittance advice or coordination of benefits, letter from an attorney or copy of a check, with the refund. If the payment from the third party resource equals or exceeds the Medicaid payment on the claim, the total Medicaid payment must be refunded to the Department. If the payment from the third party resource is less than the Medicaid payment on the claim, the total third party payment must be refunded to the Department.

Note: The Department may request NE Point of Purchase (NE-POP) pharmacy providers to void claims through the NE-POP system instead of submitting refunds.

If, after NMAP has paid, a provider learns of a third party resource which would have paid more for the service than NMAP's allowable, in cases where health insurance is the third party resource, the provider may supply the COB Unit with the third party resource information, refund the Department the full NMAP payment, and then seek recovery from the third party resource. If a Medicaid client becomes retroactively eligible for Medicare, the provider shall refund the Department the full NMAP payment and seek reimbursement from Medicare for payment unless Medicare filing time limits for dates of service on the claims have been exhausted. In cases where casualty insurance is the third party resource, the provider shall not refund Medicaid's payment and then seek recovery from a third party resource, unless the refund is requested by the Department.

3-004.09A Department Requests for Refunds: When the Department receives information that the provider has received a third party resource payment on a Medicaid paid claim, the Department shall notify the provider that a refund is due to the Department. The provider is allowed 30 days to submit a refund check, show that the refund has already been made, document that the refund request is in error, or appeal. Failure to comply with this request within 30 days shall be cause for the Department to withhold future provider payments until the situation is resolved or impose sanctions on the provider. The refund request shall constitute notice of sanction.

3-004.10 Client Rights and Responsibilities

3-004.10A Client's Rights: A provider shall not refuse to furnish services to an individual who is eligible for Medicaid because of a third party's potential liability for payment of service.

3-004.10B Client's Failure to Cooperate: A Medicaid client has the obligation to assist the provider and the Department in obtaining payment from all available third party resources. This may include complying with any requests from the insurer for additional information, ensuring that the provider or the Department receives remittance advice/coordination of benefits and/or payments from the insurer, or appearing in court in litigation situations. If the client fails to cooperate with the provider in securing third party resources, the provider may contact the COB/TPL Unit. Failure by the client to cooperate may cause the client to lose his/her Medicaid eligibility. The client will be responsible for charges on the denied services.

3-004.10C Client Responsibility When Enrolled in HMO or PPO Plan: Clients are required to utilize the services provided through and to obtain all necessary prerequisites as set out by the HMO or PPO plan (e.g., obtaining prior authorizations, using network providers, etc.). Failure to do so is considered lack of cooperation and will result in loss of Medicaid eligibility. The client is responsible for the charges on the denied services.

3-004.10D Client Responsibility When Health Insurance Premiums are Paid by the Department: If the Department determines it is cost effective to pay the premiums for a Medicaid eligible client to maintain their current commercial insurance coverage, the client shall follow any preauthorization or referral provisions of the plan or utilization of specific providers in the network. Claims denied by TPR because client did not utilize a network provider or obtain necessary authorizations or referrals will not be paid by Medicaid. The client will be responsible for the charges on the denied services.

3-004.10E Client Responsibility When Client Chooses to Enroll in Medicare Advantage (Medicare C) Plans: Medicaid will not pay claims denied by Medicare for Medicaid clients enrolled in Medicare Advantage plans who move out of the service area without complying with notification requirements. The client will be responsible for the charges on the denied services.

Claims denied by the Medicare Advantage plan because the client did not utilize a network provider or obtain necessary authorizations or referrals will not be paid by Medicaid.

3-004.11 Nebraska Medicaid Managed Care and Health Third Party Resources: Medicaid clients with Medicare or private health insurance determined to be "qualified coverage" (as indicated in 482 NAC 2-000 ff. such as full commercial coverage, HMO plans, or PPO plans) are excluded from mandatory participation in the Nebraska Health Connection. If a client becomes enrolled in both NHC and Medicare and/or a private insurance plan at the same time, the provider should contact the NHC plan on coordination of benefits issues.

The provider shall obtain prior authorization and/or referrals from all third party resources to avoid nonpayment. If the provider has difficulty obtaining third party payment or denials from the commercial plan and the policyholder is a non-custodial parent, the provider may contact COB staff for review on a case-by-case basis.

If the provider receives reimbursement from commercial insurance and/or Medicare while the client is enrolled in an NHC plan, the provider shall refund the NHC plan. Medicaid is refunded when the service was paid "fee for service" by NMAP as an exception (as indicated in 482 NAC 2-000).

3-004.12 Coordination of Benefits with Health Plans and Self-funded Insurers: These regulations implement Neb. Rev. Stat. §§ 68-926 to 68-933 governing coordination of benefits between licensed and self-funded insurers and the Nebraska Medicaid Program.

3-004.12A Definitions:

Coordinate benefits means:

1. Provide to the Department of Health and Human Services information regarding the licensed insurer's or self-funded insurer's existing coverage for an individual who is eligible for a state benefit program; and
2. Meet payment obligations to providers of health care services on behalf of Medicaid clients.

Coverage information, for other than limited benefit policies, means health information possessed by a licensed insurer or self-funded insurer that is limited to the following information about an individual:

1. Eligibility for coverage under a health plan;
2. Coverage of health care under the health plan; or
3. Benefits and payments associated with the health plan.

Coverage information for limited benefit policies means whether an individual has coverage, and, if so, a description of that coverage.

Department means the Department of Health and Human Services.

Health plan means any policy of insurance issued by a licensed insurer or any employee benefit plan offered by a self-funded insurer that provides for payment to or on behalf of an individual as a result of an illness, disability, or injury or change in a health condition.

Individual means a person covered by a state benefit program, including Medicaid, or a person applying for coverage under a state benefit program.

Licensed insurer means any insurer, except a self-funded insurer, including a fraternal benefit society, producer, or other person licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of Nebraska.

Limited benefit policy means a policy of insurance issued by a licensed insurer that consists only of one or more, or any combination of the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage for specified disease or illness; or
3. Hospital indemnity or other fixed indemnity insurance.

Medicaid means the medical assistance program established under Neb. Rev. Stat. §§ 68-901 to 68-949.

Self-funded insurer means any employer or union who provides a self-funded employee benefit plan.

3-004.12B Coverage Information Requests: The Department may request coverage information from a licensed insurer or a self-funded insurer about a specific individual without the individual's authorization to:

1. Determine an individual's eligibility for state benefit programs, including Medicaid; or
2. Coordinate benefits with state benefit programs.

The Department will specify the individual recipients for whom information is being requested.

3-004.12B1 Response to Requests: Self-funded insurers and licensed insurers must respond within 30 days of receipt of any request for coverage information from the Department, sent by first class mail. The information must be provided within thirty days after the date of the request unless good cause is shown.

3-004.12C Failure to Acknowledge and Respond to Coverage Information Requests

3-004.12C1 If a licensed insurer fails to acknowledge and respond to a request from the Department for coverage information about an individual, the Department will refer the insurer's failure to respond to the Department of Insurance under the Unfair Insurance Claims Settlement Practices Act.

3-004.12C2 If a self-funded insurer fails to acknowledge and respond to a request from the Department for coverage information about an individual, the Department may find this a violation of the requirements of 471 NAC 3-004.12B and impose a civil money penalty.

3-004.12C3 Civil Money Penalty: The Department may impose and collect a civil money penalty on a self-funded insurer who fails to respond to a

coverage information request under 471 NAC 3-004.12B if the Department finds that the self-funded insurer:

1. Committed the violation flagrantly and in conscious disregard of the requirements; or
2. Has committed violations with such frequency as to indicate a general business practice to engage in that type of conduct.

3-004.12C3a The Department may impose a civil money penalty of no more than $1,000 for each violation, not to exceed an aggregate penalty of $30,000, unless the violation by the self-funded insurer was committed flagrantly and in conscious disregard of 471 NAC 3-004.12B in which case the penalty will not be more than $15,000 for each violation, not to exceed an aggregate penalty of $150,000.

3-004.12C3b To assess a penalty, the Department will:

1. Provide written notice of the violation to the self-funded insurer. The notice will specify:
   a. The total amount of the civil money penalty;
   b. The evidence on which the civil money penalty is based;
   c. That the self-funded insurer may request, in writing, a hearing to contest the assessment of a civil money penalty in accordance with 465 NAC 6-000; and
   d. That an unpaid civil money penalty constitutes a debt to the State of Nebraska which may be collected in the manner of a lien, foreclosure, or sued for and recovered in a proper form of action in the name of the state in the District Court of the county in which the violator resides or owns property; and
2. Send by certified mail, a written notice of the civil money penalty to the last known address of the person to whom the penalty is assessed.

3-004.12C3c The Department is authorized to recover all amounts paid or to be paid to state benefit programs as a result of failure to coordinate benefits by a licensed insurer or a self-funded insurer.

3-004.12C3d The Department will submit all money collected as a civil penalty under 471 NAC 3-004.12C3 to the State Treasurer, for distribution pursuant to Article VII, Section 5 of the Constitution of Nebraska.

3-004.12D Hearing: A licensed insurer or a self-funded insurer's request for a hearing to appeal an action by the Department must comply with 465 NAC 6-000.

3-005 Prior Authorization: The Department is responsible for ensuring the appropriate expenditure of NMAP funds for medically necessary services provided to eligible clients. Prior authorization of payment for specific covered services, as a utilization control tool, is one method used to meet this responsibility. The Department uses prior authorization to -

1. Safeguard against unnecessary or inappropriate care and services;
2. Safeguard against excessive payments;
3. Assess the quality and timeliness of service;
4. Determine if less expensive, alternative care, services, or supplies could be used;
5. Promote the most effective and appropriate use of available services and facilities; and
6. Eliminate misutilization practices of providers and clients.

3-005.01 Services Requiring Prior Authorization: Services which require prior authorization of payment, prior authorization requirements, and methods are listed in the chapter of the Nebraska Department of Health and Human Services Finance and Support Manual related to the specific type of service.

3-005.02 Limitations of Prior Authorization: Prior authorization is issued only if the client is or was eligible for NMAP for the period for which services are authorized. If the client becomes ineligible for NMAP (through spend-down, suspension, or closing of the case) during the authorization period, the authorization is invalid in the period of ineligibility. The authorizing agent shall not submit a prior authorization request until eligibility for NMAP has been determined. Prior authorization is not transferable to other clients or other providers.

3-005.02A Medicare/Medicaid Eligibility: If the client is eligible for Medicare as well as Medicaid and the requested services are covered by Medicare, prior authorization is not issued. In some cases, as defined in the specific service policy, the provider must receive a denial of coverage from Medicare before a prior authorization is issued. The provider shall submit a copy of the denial with the claim form to receive payment.

3-005.03 Notification of the Client: The provider or local office shall notify the client of approval or denial of prior authorization according to the prior authorization procedures under the individual chapters of this Title.

3-006 (Reserved)

3-007 (Reserved)

3-008 Copayments

3-008.01 Copayment Schedule: The Department has established the following schedule of copayments for Medicaid services.

Service	Amount of copayment
Chiropractic Office Visits	$1 per visit
Dental Services	$3 per specified service
Durable Medical Equipment	$3 per specified service
Drugs (except birth control)	
Generic drugs	$2 copay
Brand name drugs	$3 copay
Eyeglasses	$2 per frames, lens, or frames with lens
Hearing Aids	$3 per hearing aid
Inpatient Hospital	$15 per admission
Mental Health/Substance Abuse Visits	$2 per specified service
Occupational Therapy (non-hospital based)	$1 per specified service
Optometric Office Visits	$2 per visit
Outpatient Hospital Services	$3 per visit
Physical Therapy (non-hospital based)	$1 per specified service
Physicians (M.D.'s and D.O.'s) Office Visits (Excluding Primary Care Physicians Family Practice, General Practice, Pediatricians, Internists, and physician extenders {including physician assistants, nurse practitioners, and nurse midwives} who provide primary care services)	$2 per visit
Podiatrists Office Visits	$1 per visit
Speech Therapy (non-hospital based)	$2 per specified service

Note: See 471-000-126 for a list of procedure codes for the services that are subject to copayment requirements. Drug products exempted from the copayment requirements are indicated on the Department's Drug Name/License Number Listing microfiche.

3-008.01A Excluded Services: The following services are excluded from the above copayment requirement by federal regulations:

1. Emergency services provided to treat an emergency medical condition in a hospital, clinic, office or other facility that is equipped to provide the required care. An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, that a prudent lay person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman and her unborn child) afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person; and
2. Family planning services, supplies, and drugs (such as contraceptive pills, creams, lotions etc.) provided to individuals of child-bearing age.

3-008.02 Covered Persons: All Medicaid-eligible adults age 19 or older listed below are subject to the copayment requirement:

1. Adults eligible under the Aid to Dependent Children (ADC) program;
2. Adults eligible under the Aid to Aged, Blind, and Disabled (AABD) program;
3. Adults eligible under the Refugee Resettlement Program (RRP);
4. Individuals who are receiving extended assistance for former Department wards; and
5. Individuals age 19 and 20 eligible under the Ribicoff program.

The client's Medicaid eligibility document will indicate whether the client is subject to the copayment requirement. The provider may also verify the client's copayment status by contacting the Nebraska Medicaid Eligibility System (NMES) or by using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see 471-000-50 Electronic Transactions Instruction).

3-008.02A Change in Client's Copayment Status During the Month: The client's copayment status may change during the month. If the client's copayment status changes during the month (for example, admission to a medical institution or alternate care as defined in 471 NAC 3-008.02B, or verification of pregnancy), the provider may submit documentation regarding copayments made or collected erroneously and the Department will make the appropriate adjustments to the claim. The provider shall refund the client (either cash or credit) when a copayment is erroneously collected. Providers may contact the Nebraska Medicaid Eligibility System (NMES) or use the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to verify the client's copayment status.

3-008.02B Exempted Persons: The following individuals are exempted from the copayment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);
3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;
4. Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes; and
5. Indians who receive items and/or services furnished directly by an Indian Health Care Provider or through referral from an Indian Health Care Provider under contract health services.

4. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Mental Retardation or Related Conditions; the Home and Community-Based Waiver for Children with Mental Retardation and Their Families; the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities or the Early Intervention Waiver;
5. Individuals with excess income (over the course of the excess income cycle, both before and after the obligation is met); and
6. Individuals who receive assistance under the State Disability Program (SDP).

3-008.03 Client Rights and Responsibilities: Clients listed in 471 NAC 3-008.02 as covered persons are required to pay the provider the applicable copayment amounts as specified in 471 NAC 3-008.

If a client believes that a provider has charged the client incorrectly, the client must continue to pay the copayments charged by that provider until the Department determines whether the copayment amounts are correct.

The client has the right to appeal under 465 NAC 2-001.02.

3-008.04 Collection of Copayment: The provider shall collect the copayment from the client when the service is provided. The provider shall not refuse to provide services to the client if the client is unable to pay the copayment amount at the time of the service. This does not alleviate the client's liability for the copayment amount nor does it prevent the provider from attempting to collect the copayment amount.

If it is the routine business practice of the provider to refuse service to any individual with uncollected debt, the provider may include uncollected copayments under this practice. Providers shall give sufficient notice to the client before services can be denied.

Providers shall bill their usual and customary charge regardless of whether the copayment has been collected. The provider shall not enter the copayment as a “prior payment or amount paid” amount on the claim.

A provider shall not establish a policy to automatically waive copayments or deductibles established by the Department. A provider shall not advertise or promote through newspapers, magazines, circulars, direct mail, directories, radio, television, or otherwise that the provider will waive the collection of all or any portion of the required copayments or deductibles.

The provider shall not collect a copayment amount that exceeds the provider's usual and customary charge or the NMAP payment. Copayment collected from the client must be the lowest of the established copayment amount, the provider's usual and customary charge, or the NMAP payment.

Also see 471 NAC 3-008.02A.

3-008.05 Third Party Liability: For Medicaid clients enrolled in commercial HMO or PPO plans, the Medicaid copayment may apply.

3-008.06 Medicare: For Medicare/Medicaid eligible clients, the Medicaid copayment applies. NMAP pays Medicare co-insurance and deductible amounts on Medicare-approved services minus any Medicaid copayment.