TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 3 PAYMENT FOR MEDICAID SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by the Medical Assistance Act (Nebraska Revised Statute § 68-901 et seq).

002. DEFINITIONS.

002.01 ADJUDICATE. To determine whether a claim or adjustment is to be paid or denied.

002.02 BALANCE BILLING. Billing the Department or client any amount after a provider has agreed to accept a payment as payment in full.

002.03 CASUALTY INSURER. An insurance policy which 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.

002.04 CLAIM. A request for payment for services rendered or supplied by a provider to a client.

002.05 CLEARINGHOUSE. An entity which 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.

002.06 CLIENT ASSIGNMENT OF RIGHTS. The client's action to assign to the Department his or her rights, and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights, to medical support and to payment for medical care from any liable third party, except Part A and B of Medicare. Assignment of rights is accomplished by signing the Medicaid application.

002.07 DENIAL. Non-payment of services or benefits by Nebraska Medicaid.

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

002.09 HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS). The system which 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.

002.10 INDIAN. An individual, defined at 25 United States Code (U.S.C.) sections 1603(c), 1603(f), and 1679(b), or who has been determined eligible, as an Indian, pursuant to 42 Code of Federal Regulations (C.F.R.) 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under Contract Health Services.

002.11 INDIAN HEALTH CARE PROVIDER. 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.

002.12 MEDICARE ADVANTAGE PLAN. Coordinated care plans meeting Medicare C standards, including health maintenance organizations (HMO), Provider Sponsored Organizations (PSO), Preferred Providers Organizations (PPO), religious fraternal benefits plans, and other coordinated care plans. Individuals 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.

002.13 MEDICAL SUPPORT. The obligation of a non-custodial parent to provide health insurance or pay for medical care ordered by a court or administrative body established under state law.

002.14 MEDICARE AND MEDICAID DUALLY ELIGIBLE INDIVIDUAL. Individuals dually eligible for Medicare and Medicaid during the same period of time.

002.15 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.

002.16 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.

002.17 MEDICARE PART D. A federal program, also known as the Medicare prescription drug benefit. 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 also eligible for Medicaid. Clients who are dually eligible for Medicare and Medicaid are automatically enrolled in Part D.

002.18 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 for Medicare beneficiaries.

002.19 MEDICARE PART D DRUG. Any drug, class of drugs, or therapeutic category of drugs which is not a Medicare Part D Excluded drug, regardless of formulary, prior approval, or tier status by the Part D Plan.

002.20 MEDICARE PART D EXCLUDED DRUG. Any drug, class of drugs, or therapeutic category of drugs which is specifically excluded from coverage under the Medicare Modernization Act of 2003 and amendments to the act, or as defined by federal regulations implementing the Medicare Modernization Act.

002.21 MEDICARE PART D SUPPLIES OR EQUIPMENT. Insulin syringes, needles, alcohol swabs, gauze, and other products covered by Medicare Part D Plans.

002.22 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.

002.23 PAY AND CHASE. A recovery method in which Medicaid pays the total amount allowed under Nebraska Medicaid and then seeks to recover from liable third party resources.

002.24 PREFERRED PROVIDER ORGANIZATION (PPO). 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.

002.25 PRIVATE INSURER. This includes:

(A) Any commercial insurance company offering health or casualty insurance to individuals or groups, including both experience-related and indemnity contracts;

(B) 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

(C) 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 the Employee Retirement Income Security Act.

002.26 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 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.

002.27 SHARE OF COST. The amount of the client's income which must be obligated or paid for medical care before Medicaid payment can be made.

002.28 STANDARD TRANSACTION. An electronic transaction which complies with the applicable standard adopted under federal law.

002.29 SUBROGATION. Right of the state to stand in place of the client in collection of third party resources.

002.30 THIRD PARTY RESOURCE. Any individual, entity, or program which is, or may be, contractually or legally liable to pay all or part of the cost of any medical service furnished to an individual.

002.31 TRANSACTION. The exchange of information between two parties to carry out financial or administrative activities related to health care.

002.32 TRADING PARTNER AGREEMENT. An agreement related to the electronic exchange of information.

002.33 WAIVER CLAIM. A claim for which the Department has applied and received a cost avoidance waiver from the Centers for Medicare and Medicaid Services, or claims which are mandated to have cost avoidance waived under 42 C.F.R. 433.139.

002.34 WARRANT. A paper check or electronic funds transfer.

003. APPROVAL AND PAYMENT.

003.01 APPROVAL. Payment for medical care and services through Medicaid funds must be approved by the Department.

003.01(A) CONDITIONS FOR APPROVAL. Claims will be approved for payment when all of the following conditions are met:

(i) The provider was enrolled and eligible for payment under the Nebraska Medicaid State Plan on the date the service was provided;
(ii) The client was eligible for Medicaid when the service was provided, or the service was provided during the period of retroactive eligibility;
(iii) 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);
(iv) The medical care and services are within the guidelines of Medicaid;
(v) The client's clinical record must contain information to meet state requirements; and
(vi) A trading partner agreement has been approved, if required, for clearinghouses, billing agents, and providers submitting claims using electronic transactions.

003.01(B) EXCEPTIONS TO TIMELY FILING OF CLAIMS. Payment may be made by the Department for claims received more than six months after the date of service if the circumstances which delayed the submittal were beyond the provider's control. The Department will determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

003.01(C) TIMELY PAYMENT OF CLAIMS. The Department must pay claims within 12 months of the date of receipt of the claim. This time limitation does not apply to:

(i) Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system;
(ii) 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;

(iii) Claims from providers under investigation for alleged fraud or abuse;

(iv) Payments made:

(1) In accordance with a court order;

(2) To carry out hearing decisions or agency corrective actions taken to resolve a dispute;

(3) 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

(4) Third party casualty situations as specified in 471 NAC 3-004.06C.

003.01(D) DENIAL. The Department will not pay claims received more than two years after the date of service, except under the circumstances specified in this chapter.

003.01(E) 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.

003.02 PAYMENT.

003.02(A) UPPER LIMITS. The Department has established upper limits for payment as described in each provider chapter.

003.02(B) COVERAGE EXCEPTION. Certain medical services, while being medically necessary, may exceed the Nebraska Medicaid 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.

003.02(C) PAYMENT IN FULL. Providers participating in Nebraska Medicaid agree to accept as payment in full the amount paid according to the Department's payment methodologies after all other sources have been exhausted.

003.02(C)(i) 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.

003.02(D) CHARGES TO THE GENERAL PUBLIC. Providers will not exceed their charges to the general public when billing the Department. A provider who offers a discount to certain individuals will apply the same discount to Medicaid clients who would otherwise qualify for the discount.

003.02(E) METHOD OF PAYMENT. Payment for all approved medical services within the scope of Nebraska Medicaid will be made by electronic funds transfer to the provider who supplied the services.

003.02(F) BILLED CHARGES. If the provider's billed charges are less than the Department's allowable payment, the Department pays the provider's billed charges.

003.02(F)(i) EXCEPTION. Inpatient hospital services are paid on a diagnosis-related group or per diem basis, regardless of billed charges.

003.03 POST-PAYMENT REVIEW. Payment for a service does not indicate compliance with Department policy. Monitoring is accomplished by post-payment review to verify Department policy has been followed. A refund will be requested if post-payment review finds payment has been made for claims or services not in compliance with Department 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.

003.04 PAYMENT FOR MEDICAL EXPENSES. Payment may not be made from Department funds for medical expenses which have been paid from public or private sources. Individuals who are otherwise eligible but who have excess income must obligate the excess amount for medical care before payment for medical services can be approved through Nebraska Medicaid.

003.05 ADJUSTMENTS TO PAYMENT REDUCTIONS OR DISALLOWANCES. Providers are restricted to a maximum time limitation of 90 days to request an adjustment to a claim, regardless of the reason for the adjustment or whether the claim was disallowed in part or in whole, unless documentation of extenuating circumstances is submitted to and approved by the Department. The 90-day limitation begins with the payment date of the paper remittance advice or with the payment date of the electronic remittance advice.

003.06 REFUNDS.

003.06(A) 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 the refund has already been made, to document why the refund request is in error, or appeal. The provider's failure to respond within 30 days is cause for the Department to recoup from future provider payments until the refund is paid in full or to sanction the provider. The refund request constitutes notice of the sanction to recoup from future payments. Refunds resulting from third party resource payment must also be made as required in this chapter.

003.06(B) THIRD PARTY LIABILITY REFUNDS. When third party liability payments are received after a claim has been submitted to the Department, the provider must 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.

003.06(C) PROVIDER REFUNDS TO THE DEPARTMENT. Providers have the responsibility to review all payments to ensure no overpayments have been received. The provider must refund all overpayments to the Department within 30 days of identifying the overpayment.

003.07 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 in order to examine the accuracy of a determination which is otherwise final. The Director is the sole authority in deciding whether to reopen.

003.07(A) SITUATIONS ALLOWING FOR REOPEN. Action to reopen may be taken:

(i) On the initiative of the Department within the three-year period;

(ii) 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

(iii) At any time fraud or abuse is suspected.

003.07(B) FAIR HEARING. The right to a fair hearing does not apply to a finding by the Director which indicates a reopening or correction of a determination or decision is not warranted.

003.08 BILLING THE CLIENT. Providers participating in Nebraska Medicaid agree to accept payment from the Department as payment in full. The provider will not bill the client for Nebraska Medicaid covered services if the claim is denied by the Department for lack of medical necessity or for failure to follow a procedural requirement. The provider will not bill the client for services covered by Nebraska Medicaid. It is not a violation of Department regulations for the provider to bill the client for services not covered by Nebraska Medicaid. It is not a violation for a provider to bill the client for services when it is determined the client has received money from a third party resource and the money was designated to pay medical bills. If the client agrees in advance in writing to pay for the non-covered service, the provider may bill the client.

003.08(A) VERIFICATION OF ELIGIBILITY. The provider has the responsibility to verify the client's eligibility for Medicaid and any limitations which apply to a specific client.

003.09 SECTION 1122 SANCTIONS. When the United States 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 will withhold the federal and the state share of the capital expenditure.

004. BILLING REQUIREMENTS.

004.01 CLAIMS SUBMISSION. Providers will submit claims for payment for medical services on the appropriate Medicaid billing forms as identified by the Department or the appropriate health care claim format for electronic transactions. Billing requirements for specified services are found in the applicable 471 NAC chapter.

004.02 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:

(A) 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;
(B) 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;
(C) The amounts claimed are in compliance with the Department's policies, and no additional charge has been or will be made;
(D) The information on the claim is true, accurate, and complete;
(E) Each service is documented in the provider's files, and documentation is available to the Department, the United States Department of Health and Human Services, and state and federal fraud and abuse units; and
(F) The provider understands payment and resolution of this claim will be made from federal and state funds, and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

004.03 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 which 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 this chapter.

004.04 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 this chapter.

004.05 ELECTRONIC CLAIMS AND COMPUTER ENCODED CLAIM DOCUMENTATION. The provider will allow the authorized representatives of the United States Department of Health and Human Services, 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 representative's access to its records under the service provider agreement.

005. THIRD PARTY RESOURCES.

005.01 THIRD PARTY RESOURCE PAYMENT. All third party resources available to a Medicaid client must be utilized for all or part of their medical costs before Medicaid. 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.

005.01(A) EXCEPTIONS. The Nebraska Chronic Renal Disease Program and the Medically Handicapped Children's Program are not included as a third party resource.

005.02 AVAILABILITY OF THIRD PARTY RESOURCE INFORMATION. The Coordination of Benefits and Third Party Liability Unit of the Department maintains all known current health

insurance, casualty insurance, and Medicare coverage on the Nebraska Medicaid Eligibility System (NMES). Providers may also obtain this information using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction. If the provider becomes aware of any additional third party resources, the provider must contact the Department and report the new sources.

005.02(A) REQUEST FOR RELEASE OF PATIENT ACCOUNT INFORMATION. To alert the Department to a potential third party resource, the provider must notify the Department when 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.

005.03 PAYOR OF LAST RESORT. Medicaid clients who have third party resources must exhaust these resources before Medicaid considers payment for services. Medicaid will not pay for medical services as a primary payor if a third party resource is contractually or legally obligated to pay for the service.

005.03(A) BILLING THIRD PARTY RESOURCES. Providers must bill all third party resources and the client, when there is a share of cost obligation, for services provided to the client, except for waiver claims. Providers must submit all charges and Medicare covered services provided to Medicare and Medicaid dually eligible individuals to Medicare plus any Medicare supplement plans for resolution prior to billing Medicaid.

005.03(B) WAIVER CLAIMS. Certain services, defined as waiver claims, are an exception to the requirements of this chapter. Providers may submit these claims to Medicaid before submitting to a third party resource. Nebraska Medicaid pays these claims and Department staff initiate recovery activities for any third party resource. This does not prohibit the provider from billing the third party resource before billing Medicaid. In these situations, the provider does not bill Medicaid until the claim is resolved.

005.03(C) SERVICES NOT COVERED BY MEDICARE. Nebraska Medicaid may cover services within the scope of Nebraska Medicaid which are not covered by Medicare. Nebraska Medicaid does 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 not covered by Medicare, documentation of the Medicare denial is not required.

005.04 MEDICARE PART A AND B DEDUCTIBLE AND COINSURANCE. In some cases, 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 after crediting any amount received from Medicare for Medicare-covered services and crediting any amount received from any third party resource, Medicaid will pay the lesser of the Medicare or Medicaid allowable amount of any remaining amount due.

005.04(A) MEDICARE PART D MONTHLY PREMIUM, DEDUCTIBLE, CO-INSURANCE, AND COVERAGE GAPS. Medicaid does not pay the premium, deductible, co-insurance, copays, or coverage gaps for Medicare Part D.

005.04(B) 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:

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

(ii) If the Medicaid rate and payment for a claim exceeds the Medicare payment amount for the claim, Medicaid reimbursement is the lesser of:

(1) The difference between the Medicaid rate and payment minus the Medicare payment amount; or

(2) The Medicare coinsurance and deductible, if any, for the claim.

005.05 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 Medicaid equals or exceeds the Medicaid allowable amount. The provider may only bill the client for services not covered by Nebraska Medicaid, for Nebraska Medicaid copayment fees, where applicable, or if the client has received payment from the third party resource.

005.05(A) MEDICARE PART A AND PART B. Department payment of Medicare coinsurance and deductible constitutes payment in full. The provider will not balance bill.

005.05(B) MEDICARE ADVANTAGE. Department payment of Medicare Advantage coinsurance and deductible constitutes payment in full to the provider. The provider will not balance bill.

005.05(C) MEDICARE PART D. Nebraska Medicaid does not pay premiums, deductibles, co-insurance, copays, or coverage gaps for Medicare Part D.

005.05(D) MEDICARE WAIVER OF LIABILITY. When a Medicare and Medicaid dually eligible individual signs a Medicare Waiver of Liability and Medicare denies the claim as not reasonable and necessary, Nebraska Medicaid will not pay the claim.

005.05(E) USE OF CONTRACTS BY MEDICARE AND MEDICAID DUALLY ELIGIBLE INDIVIDUALS. If providers negotiate private contracts with Medicare and Medicaid dually eligible individuals 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.

005.05(F) 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 Nebraska Medicaid.

005.05(G) PROVIDER'S FAILURE TO COOPERATE IN SECURING THIRD PARTY PAYMENT. The provider's failure to file necessary claims for third party resources, except waiver claims, or to cooperate in securing payments by other third party resources is

grounds for denial of the claims. If Nebraska Medicaid denies claims for these services, the client cannot be billed unless the payment went to the client.

005.06 FILING CLAIMS WITH THIRD PARTY RESOURCES.

005.06(A) 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 cooperation is not in the best interests of the individual or the person to whom Medicaid is being furnished because it is anticipated cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person as described in chapter one of this title.

005.06(B) TIMELY FILING OF CLAIMS WITH HEALTH INSURANCE. Providers must 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 third party resource has not been resolved. If the provider fails to submit a claim or fails to contact the Department within 12 months from the date of service, Nebraska Medicaid will not pay the claim.

005.06(B)(i) DENIAL DUE TO THIRD PARTY RESOURCE. If the provider files a claim with Nebraska Medicaid within 12 months of the date of service and receives 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 must submit the claim adjustment to Nebraska Medicaid 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.

005.06(C) TIMELY FILING OF CLAIMS WITH CASUALTY INSURANCE. Providers must submit claims within 24 months of the date of service.

005.06(C)(i) EXCEPTION. The Department can make payment beyond 24 months if the provider can document action was taken to obtain payment from the third party. If a provider has received a denial from the Department due to the existence of casualty insurance coverage, the provider has sought payment from the third party, and the provider has waited 24 months without receiving payment from the third party, the provider can request the Department reconsider payment. If the provider has filed a lien, the provider must release the lien upon receipt of payment from the Department. These situations are reviewed on a case by case basis.

005.06(D) FILING MEDICAID CLAIMS AFTER RESOLVING THIRD PARTY RESOURCES. Providers will bill Nebraska Medicaid 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 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.

005.06(D)(i) BILLING THE USUAL AND CUSTOMARY CHARGE. When billing Nebraska Medicaid, the provider must bill the usual and customary charge for each service. The provider cannot 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.

005.06(D)(ii) ADJUSTMENT REQUEST. After the provider has submitted a claim with third party resource documentation and the Department has adjudicated the claim for payment, if 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.

005.07 THIRD PARTY RESOURCE DENIALS.

005.07(A) HEALTH INSURANCE DENIALS. Nebraska Medicaid will recognize and consider payment on claims the health insurance has denied with a valid health insurance denial.

005.07(B) MEDICARE DENIALS. Nebraska Medicaid will recognize and consider payment on claims Medicare has denied when the claim is submitted with a valid Medicare denial.

005.07(B)(i) EXCEPTION. The Department will not consider payment for services which have been denied by Medicare for lack of medical necessity.

005.07(C) CASUALTY INSURANCE DENIALS. Nebraska Medicaid will recognize and consider payment on claims involving casualty coverage denial when the claim is submitted with a valid casualty denial.

005.07(C)(i) PAYMENT PENDING LIABILITY DETERMINATION. The insurer's statement indicating payment cannot be made at this time due to a pending liability determination or litigation is not a valid denial.

005.08 FILING ELECTRONIC CLAIMS WITH THIRD PARTY RESOURCES. Medicaid will accept electronic claims when third party resources are available. The health insurance and Medicare documentation is required.

005.08(A) AUTOMATIC TRANSFER OF CLAIMS FROM MEDICARE. Nebraska Medicaid 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 and remittance advice documentation, if applicable.

005.09 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 Nebraska Medicaid for the services. The provider must bill Nebraska Medicaid within 60 days from the date on the third party reversal document and

refund. The provider must submit documentation of the reversal with the claim. The claim may be considered for payment by Nebraska Medicaid only if the date of service is no more than 24 months from the date of receipt of claim.

005.10 PRIOR AUTHORIZATION AND THIRD PARTY RESOURCES. The provider must resolve all third party resources before Nebraska Medicaid can consider paying a claim regardless of whether Medicaid prior authorization has been given.

005.11 MEDICAID ELIGIBILITY AND THIRD PARTY RESOURCES. The provider must resolve all third party resources before Nebraska Medicaid can consider paying a claim, regardless of whether the client is eligible for Medicaid, with the exception of waiver claims. A client's eligibility for Nebraska Medicaid does not guarantee payment of a claim.

005.12 LONG-TERM CARE INSURANCE POLICIES. A long-term care indemnity policy is considered a health insurance policy when the policy allows assignment of benefits and covers medical care based on specified criteria. Long-Term Care insurance which meets this criteria is not considered income for eligibility determination.

005.12(A) NURSING FACILITY CLAIMS. Because nursing facility claims are included in the category of "waiver claims," Nebraska Medicaid will pay these claims at the specific per diem for the client, less any excess income or share of cost the client is obligated to pay the provider for the monthly services. The Coordination of Benefits Unit will seek recovery on all of these policies. Because the claims have been paid, the provider will not bill the insurer. The provider must assist the Coordination of Benefits Unit in obtaining reimbursement from these policies by furnishing any medical documentation the insurer requests.

005.12(B) BILLING LONG-TERM CARE INSURANCE. 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 must be sent to the Coordination of Benefits and Third Party Liability Unit.

005.12(C) PAYMENT RECEIVED BY THE DEPARTMENT. 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 will apply the excess to any Medicaid expenditure for the Medicaid client regardless of whether the expenditure was covered by the third party. The application of the excess third party liability payment is not limited to a particular Medicaid service and can be applied to any claims paid by Medicaid. After the excess payment has been applied to all claims, any remaining amount will be paid to the client or the client’s authorized representative.

005.13 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. The County Attorney's staff or Child Support Enforcement staff will notify the Coordination of Benefits and Third Party Liability Unit of any health insurance coverage and medical support court orders obtained for a child who is eligible for Nebraska Medicaid. When a non-custodial parent is ordered by the court to furnish health insurance 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 will pay the claims and the Department will seek recovery from the health insurer or non-custodial parent.

005.13(A) BILLING WHEN A COURT ORDER EXISTS. To determine whether a court order exists, the provider may contact the Coordination of Benefits and Third Party Liability 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.

005.13(B) SEEKING PAYMENT FROM THE NON-CUSTODIAL PARENT. 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 will 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 must 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 must refund Medicaid according to the requirements of this chapter.

005.13(C) HEALTH INSURER OBLIGATION WHEN THE NON-CUSTODIAL PARENT HAS A MEDICAL SUPPORT COURT ORDER. A health insurer cannot deny a child insurance coverage if the non-custodial parent has a court or administrative order for medical support. An insurer must provide the custodial parent 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. § 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 must contact the Department.

005.14 PROVIDER REFUNDS TO THE DEPARTMENT. When a provider receives payment from a third party resource on a claim previously paid by Nebraska Medicaid, the provider must submit a refund to the Department. The provider must include the third party documentation with the refund. If the payment from the third party resource equals or exceeds the Nebraska Medicaid payment on the claim, the total payment must be refunded to the Department. If the payment from the third party resource is less than the Nebraska Medicaid payment on the claim, the total third party payment must be refunded to the Department.

005.15 BILLING THIRD PARTY RESOURCES AFTER NEBRASKA MEDICAID PAYMENT. If, after Nebraska Medicaid has paid, a provider learns of a third party resource which would have paid more for the service than Nebraska Medicaid, in cases where health insurance is the third party resource, the provider must supply the Department with the third party resource information, refund the Department the full Nebraska Medicaid payment, and then seek recovery from the third party resource. If a Medicaid client becomes retroactively eligible for Medicare, the provider must refund the Department the full Nebraska Medicaid 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 will not refund Nebraska Medicaid's payment and then seek recovery from a third party resource, unless the refund is requested by the Department.

005.15(A) DEPARTMENT REQUESTS FOR REFUNDS. When the Department receives information indicating the provider has received a third party resource payment on a Medicaid paid claim, the Department will request a refund from the provider. The provider has 30 days to submit a refund check, show the refund has already been made, document the refund request is in error, or appeal. Failure to comply with this request within 30 days is cause for the Department to withhold future provider payments until the situation is resolved or impose sanctions on the provider. The refund request constitutes notice of sanction.

005.16 CLIENT RIGHTS AND RESPONSIBILITIES.

005.16(A) CLIENT RIGHTS. A provider cannot refuse to furnish services to an individual who is eligible for Nebraska Medicaid because of a third party's potential liability for payment of service.

005.16(B) FAILURE TO COOPERATE. A Nebraska 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 the provider or the Department receives remittance advice, coordination of benefits, and 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 Department. Failure by the client to cooperate may cause the client to lose Nebraska Medicaid eligibility. The client will be responsible for payment of the denied services.

005.16(C) CLIENT RESPONSIBILITY WHEN ENROLLED IN A HEALTH MAINTENANCE ORGANIZATION OR PREFERRED PROVIDER ORGANIZATION PLAN. Clients are required to utilize the services provided through and obtain all necessary prerequisites as set out by the health maintenance organization or preferred provider organization. Failure to do so is considered lack of cooperation and may result in loss of Medicaid eligibility. The client is responsible for the payment of the denied services.

005.16(D) 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 his or her current commercial insurance coverage, the client must follow any preauthorization or referral provisions of the plan or utilization of specific providers in the network. Claims denied by third party resources 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 payment of the denied services.

005.16(E) CLIENT RESPONSIBILITY WHEN CHOOSING TO ENROLL IN MEDICARE ADVANTAGE PLANS. Nebraska 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 or who do not utilize a network provider or obtain necessary authorizations and referrals. The client will be responsible for payment of the denied services.

005.17 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 determine eligibility for state benefit programs or coordinate benefits with state benefit programs. The Department will specify the individual recipients for whom information is being requested.

005.17(A) 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. The information must be provided within thirty days after the date of the request unless good cause is shown.

005.17(B) FAILURE TO ACKNOWLEDGE AND RESPOND TO COVERAGE INFORMATION REQUESTS. 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 this chapter and impose a civil money penalty.

005.17(C) CIVIL MONEY PENALTY. 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 the requirements of this chapter in which case the penalty will not be more than $15,000 for each violation, not to exceed an aggregate penalty of $150,000.

005.17(D) HEARING. A licensed insurer or a self-funded insurer's request for a hearing to appeal an action by the Department must comply with Department regulations.

005.18 SERVICES REQUIRING PRIOR AUTHORIZATION. Services which require prior authorization for payment of claims, 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.

005.18(A) LIMITATIONS OF PRIOR AUTHORIZATION. Prior authorization is issued only if the client is eligible for Nebraska Medicaid for the period for which services are authorized. If the client becomes ineligible for Nebraska Medicaid during the authorization period, the authorization is invalid in the period of ineligibility. The authorizing agent will not submit a prior authorization request until eligibility for Nebraska Medicaid has been determined. Prior authorization is not transferable to other clients or other providers.

005.18(B) DUAL MEDICARE AND 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 must submit a copy of the denial with the claim form to receive payment.

005.18(C) NOTIFICATION OF THE CLIENT. The provider or Department will notify the client of approval or denial of prior authorization according to the prior authorization procedures under the individual chapters of this Title.

006. COPAYMENTS.

006.01 COPAYMENT SCHEDULE. The Department has established the following schedule of copayments for Medicaid services:

(A)	Chiropractic Office Visits	$1 per visit
(B)	Dental Services	$3 per specified service
(C)	Durable Medical Equipment	$3 per specified service
(D)	Drugs (except birth control)	
	(i) Generic drugs	$2 copay
	(ii) Brand name drugs	$3 copay
(E)	Eyeglasses lens	$2 per frames, lens, or frames with
(F)	Hearing Aids	$3 per hearing aid
(G)	Inpatient Hospital	$15 per admission
(H)	Mental Health/Substance Abuse Visits	$2 per specified service
(I)	Occupational Therapy (non-hospital based)	$1 per specified service
(J)	Optometric Office Visits	$2 per visit
(K)	Outpatient Hospital Services	$3 per visit
(L)	Physical Therapy (non-hospital based)	$1 per specified service
(M)	Physicians (M.D.'s and D.O.'s) Office Visits	$2 per visit
	(i) 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.	
(N)	Podiatrists Office Visits	$1 per visit
(O)	Speech Therapy (non-hospital based)	$2 per specified service

006.02 EXCLUDED SERVICES. The following services are excluded from the above copayment requirement by federal regulations:

(A) Emergency services provided to treat an emergency medical condition in a hospital, clinic, office, or other facility equipped to provide the required care. An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, which a prudent layperson 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

(B) Family planning services, supplies, and drugs provided to individuals of child-bearing age.

006.03 COVERED PERSONS. All Medicaid-eligible adults age 19 or older listed below are subject to the copayment requirement:

(A) Adults eligible under the Aid to Aged, Blind, and Disabled program;
(B) Adults eligible under the Refugee Resettlement Program; and
(C) Individuals who are receiving extended assistance for former Department wards.

006.04 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, the provider may submit documentation regarding copayments made or collected erroneously and the Department will make the appropriate adjustments to the claim. The provider will refund the client when a copayment is erroneously collected. Providers can contact the Nebraska Medicaid Eligibility System or use the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction to verify the client's copayment status.

006.05 EXEMPTED PERSONS. The following individuals are exempted from the copayment requirement:

(A) Individuals age 18 or younger;
(B) Pregnant women through the immediate postpartum period, beginning on the last day of pregnancy and extending 60 days. The post-partum period ends on the last day of the month in which day 60 occurs;
(C) Any individual who is an inpatient in a hospital, long term care facility, 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 or her income required for personal needs for medical care costs;
(D) Indians who receive items and services furnished directly by an Indian Health Care Provider or through referral from an Indian Health Care Provider under contract health services;
(E) Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults; the Home and Community-Based Waiver for Children; the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities or the Early Intervention Waiver;
(F) Individuals with excess income, both before and after the obligation is met;
(G) Individuals who receive assistance under the State Disability Program;
(H) Individuals eligible for IV-E assistance;
(I) Individuals in hospice care;
(J) Individuals eligible in the Breast and Cervical Cancer category;
(K) Family planning services and supplies;
(L) Individuals approved for emergency services only; and
(M) Individuals enrolled in managed care, though the managed care organization may assess copays as long as they offer at least the same exemptions listed in this section.

006.06 CLIENT RIGHTS AND RESPONSIBILITIES. Clients subject to copayments are required to pay the provider the applicable copayment amounts. If a client believes a provider has charged the client incorrectly, the client must continue to pay the copayments charged by the provider until the Department determines whether the copayment amounts are correct. The client has the right to appeal.

006.07 COLLECTION OF COPAYMENT. The provider will collect the copayment from the client when the service is provided. The provider cannot 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.

006.07(A) UNCOLLECTED COPAYMENTS. 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 must give sufficient notice to the client before services can be denied.

006.07(B) PROVIDER BILLING FOR SERVICES SUBJECT TO COPAYMENT. Providers will bill their usual and customary charge regardless of whether the copayment has been collected. The provider will not enter the copayment as a prior payment or amount paid amount on the claim.

006.07(C) PROVIDER WAIVER OF COPAYMENT. A provider cannot establish a policy to automatically waive copayments or deductibles established by the Department. A provider cannot advertise or promote waiver of the collection of all or any portion of the required copayments or deductibles.

006.07(D) USUAL AND CUSTOMARY CHARGE. The provider cannot collect a copayment amount which exceeds the provider's usual and customary charge or the Nebraska Medicaid payment. Copayment collected from the client must be the lowest of the established copayment amount, the provider's usual and customary charge, or the Nebraska Medicaid payment.

006.08 THIRD PARTY LIABILITY. For Medicaid clients enrolled in commercial Health Maintenance Organization or Preferred Provider Organization plans, the Nebraska Medicaid copayment may apply.

006.09 MEDICARE. For Medicare and Medicaid dually eligible clients, the Nebraska Medicaid copayment applies. Nebraska Medicaid pays Medicare co-insurance and deductible amounts on Medicare-approved services less any Medicaid copayment.