Nebraska Department of Health and Human Services
Health Plan Advisory No. 16-03

DATE: December 16, 2016

TO: Nebraska Heritage Health Plans

FROM: Calder Lynch, Director
Division of Medicaid & Long-Term Care

BY: Heather Leschinsky, Deputy Director
Delivery Systems

RE: Retroactive Enrollment

This Health Plan Advisory is being issued to provide instructions to Heritage Health Plans on what is expected of the plans for members who were determined eligible for retroactive Medicaid coverage.

To ensure providers are able to receive reimbursement for medically necessary services received prior to the Medicaid eligibility decision date, the following policies have been established for all plans for claims filed by providers with dates of service prior to the effective date of plan enrollment:

1. The plans must establish their timely filing limit deadlines based on the date the member was enrolled in the plan and not the date of service.
2. Plans must perform retro-active medical necessity determinations for services that would normally require prior authorization for in-network or out-of-network providers. The plans must utilize the same criteria for medical necessity as would be required if the authorization request was submitted prior to the service being provided.
3. Plans that require authorization for services for out-of-network providers must accept retro-active authorization requests for those services. If the service does not require authorization for in-network providers, the plans must not require medical necessity documentation for the authorization.
4. All providers regardless of network status must be enrolled as a provider in Nebraska Medicaid for the dates the services were provided to be considered for reimbursement.

If you have any questions about this advisory please contact, Lisa Neeman at lisa.neeman@nebraska.gov. Health plans should also copy their contract manager.