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Division of Medicaid and Long-Term Care

Nebraska Medicaid Provider Manual

January 2026

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Version History

Version	Publication Date	Description
1.0	January 6, 2026	Initial version of the MLTC Provider Manual published.
1.0	January 7, 2026	Edits to Section 3.1 and 3.2.

1. Introduction

1.1 Welcome

Thank you for your interest or participation in the programs and services overseen by the Nebraska Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care (MLTC). MLTC oversees the Nebraska Medicaid program.

Medicaid provides health care services to low-income families, seniors, and individuals with disabilities.

Medicaid home and community-based service (HCBS) waivers are administered by the Division of Developmental Disabilities (DDD). Providers of Medicaid waiver services should refer to the resources from DDD below:

- DDD Provider Policy Manual: https://dhhs.ne.gov/Guidance%20Docs/DHHS-DD%20Policy%20Manual.pdf
- Services on the Aged and Disabled Waiver: https://dhhs.ne.gov/Pages/Medicaid-Aged-and-Disabled-Waiver.aspx

1.2 Purpose of Provider Manual

This manual outlines Nebraska Medicaid's coverage policy as well as the requirements and procedures for health care providers participating with Nebraska Medicaid.

This manual is a supplement to:

- Federal law, including the Social Security Act
- The Code of Federal Regulations (CFR)
- The Medicaid HCBS Waiver applications
- Nebraska Revised State Statutes (Neb. Rev. Stat. §)
- The Nebraska Administrative Code (NAC) of Regulations
- Nebraska Medicaid State Plan (Title XIX)

1.3 Organization of Provider Manual

Organization of Content

A table of contents is followed by 5 chapters, each of which describes general provider expectations and requirements.

Numbering System

A numbering system is used to ensure readability and ease in referencing sections and pages within chapters. The numbering system in the manual is as follows:

- Each chapter is numbered 1, 2, 3, etc.
- Sections within chapters are numbered 1.1., 1.2., etc.
- Pages are numbered sequentially throughout the entire manual.

1.4 Distribution of Manual and Updates

Distribution

This manual is available on the Medicaid Providers page of the Medicaid and Long-Term Care website.

Updates

MLTC updates the manual when there are changes in policy and requirements. This Policy Manual supersedes all previous policy manuals and provider bulletins. When changes to the manual are needed:

- MLTC will make a reasonable effort to provide notification to stakeholders about the changes.
- Subscribers to the Medicaid Providers webpage will get an automated email when the webpage is updated.
- The Provider Manual displays a publication date, which will be revised accordingly as content updates are made to ensure accuracy.
- In the event of significant changes, Nebraska Medicaid will publish a Provider Bulletin to formally notify providers and direct them to the updated page(s).

1.5 Terminology

Beneficiary: In this manual, beneficiary refers to individuals receiving health coverage through the Nebraska Medicaid and Long-Term Care program.

CHIP: CHIP refers to the Children's Health Insurance Program. CHIP is a health coverage for certain children who are without other health insurance and who do not qualify for Medicaid. It provides the same services covered under Medicaid in Nebraska.

CMS: CMS refers to the United States Centers for Medicare and Medicaid Services. CMS is the federal agency that manages Medicare, Medicaid, CHIP, and the Health Insurance Marketplace.

DDD: DDD refers to the Nebraska Division of Developmental Disabilities. DDD is a division of DHHS. Certain Nebraska Medicaid home and community-based service (HCBS) waivers are administered by DDD.

DHHS: Within this manual, DHHS refers to the Nebraska Department of Health and Human Services (DHHS).

FFS: FFS refers to fee-for-service. In FFS delivery, Nebraska Medicaid acts as the direct payer for healthcare services provided to Medicaid beneficiaries, rather than utilizing a managed care intermediary.

HCBS: HCBS refers to Home and Community-Based Services. HCBS services allow people to receive services at home or in their community rather than in isolated settings. Many services are provided via waivers.

MCO: MCO refers to Managed Care Organization. In Nebraska, the three Medicaid MCOs provide care coordination for physical health, behavioral health, dental, and pharmacy programs.

MCO: MCO refers to Managed Care Organization. In Nebraska, the three Medicaid MCOs provide care coordination for physical health, behavioral health, dental, and pharmacy programs. MCOs may also be referred to as health plans or managed care plans.

MLTC and Nebraska Medicaid: MLTC refers to the Nebraska Division of Medicaid and Long-Term Care. In this manual, the terms MLTC and Nebraska Medicaid may be used interchangeably.

Waiver: Medicaid waivers allow states additional flexibility in the delivery of Medicaid services beyond what is federally required.

Patient: In the context of this manual, a patient is an individual receiving or scheduled to receive medical care. The word beneficiary may be used to refer to medical patients who are enrolled in Medicaid.

Waiver: Medicaid waivers allow states additional flexibility in the delivery of Medicaid services beyond what is federally required.

1.6 Fee-for-Service and Managed Care

Nebraska Medicaid providers who are delivering fee-for-service (FFS) healthcare services should use this manual as a reference point for policies that determine how they interact with the Medicaid program.

Nebraska Medicaid providers who contract with a Heritage Health MCO should note that this provider manual outlines the general requirements of the Nebraska Medicaid program. These providers should also refer to the provider manual(s) of the MCO(s) with which they're contracted. The Heritage Health MCOs must cover all Medicaid-covered services listed in this provider manual. However, the MCOs may place appropriate limits on covered services consistent with medical necessity or to ensure appropriate utilization.

For more information on each MCO's coverage and authorization processes, see the webpages and contact information below:For more information on each MCO's coverage and authorization processes, see the webpages and contact information below:

- **Molina**
  - Provider materials: https://www.molinahealthcare.com/providers/ne/medicaid/resources/provider-materials.aspx
  - Provider services phone number: (844) 782-2678
- **Nebraska Total Care**
  - Provider resources: https://www.nebraskatotalcare.com/providers/resources/forms-resources.html
  - Provider services phone number: (844) 385-2192
- **UnitedHealthcare:**
  - Provider manuals (by state): https://www.uhcprovider.com/en/admin-guides/cp-admin-manuals.html
  - Provider services phone number: (866) 331-2243

1.7 Program Contact Information

For questions regarding this provider manual, please email DHHS.MLTCExperience@nebraska.gov.

2. Beneficiary Eligibility and Rights

This section of the provider manual will provide a brief overview of Medicaid beneficiary eligibility processes and their rights as Medicaid beneficiaries so that providers can be better equipped to answer questions they may receive from their patients.

2.1 Overview

To be eligible for Medicaid in Nebraska, an individual must submit an application for coverage to Nebraska DHHS. Some of the criteria the Medicaid program needs to know about an individual in order to determine whether they are eligible for coverage include:

- Age
- Income
- Resources
- U.S. citizenship or satisfactory noncitizen status
- Nebraska residency
- Social Security number
- Household members

Further details on the main factors of Medicaid eligibility are described throughout Title 477 of the NAC.

2.2 Application Process

If your patient is interested in applying for Medicaid, they can do so in a few different ways. Those include:

- Online via the iServe Nebraska Portal (https://iserve.nebraska.gov/)
- Call one of the numbers below to apply over the phone or to request a paper application. Statewide phone lines are open from 8:00 a.m. to 6:00 p.m. (Central) Monday through Friday.
    - (855) 632-7633
    - In Lincoln: (402) 473-7000 (until 5:00 p.m. Central)
    - In Omaha: (402) 595-1178 (until 5:00 p.m. Central)
- Visit a local DHHS office (https://dhhs.ne.gov/Pages/Public-Assistance-Offices.aspx)

State Regulations in Title 477 NAC 3 provide further information on the application process.

2.3 Presumptive Eligibility

In limited circumstances, some qualified providers may make presumptive eligibility determinations when patients in their care may qualify for Medicaid based on preliminary declared information. Individuals approved will be eligible for Medicaid services during a temporary presumptive time period.

Hospital-based providers enrolled with Medicaid may make presumptive eligibility determinations, as well as any Medicaid-enrolled provider who provides services to pregnant women. To be able to make presumptive eligibility determinations, these providers must complete a form to declare to Nebraska Medicaid that they are interested in being able to make these determinations, complete a training course on the Presumptive Eligibility program, and obtain approval from DHHS.

More information on the Presumptive Eligibility program is available on the DHHS Website: https://dhhs.ne.gov/Pages/Medicaid-Provider-Presumptive-Eligibility.aspx

2.4 Income Limits

Nebraska Medicaid's income limits are based on the federal poverty level and are applied on a per-month basis. The federal poverty level is updated annually. Income limits vary depending on which Medicaid eligibility category applies to the applicant. Beneficiaries are responsible for reporting to Medicaid any changes in their income.

Income limits are published in the following guide: Medicaid Income Levels, Federal Poverty Levels, and Resources

2.5 Beneficiary Appeal Process

Medicaid applicants and beneficiaries have the right to appeal any action, inaction, or failure to act with reasonable promptness by DHHS. Providers may also assist their patients and submit appeals on their behalf. The applicant or beneficiary must request a fair hearing within 90 days following the mailing date of the Notice of Action describing the action they want to appeal. Appealable actions include:

- Their application is denied;
- Their application is not acted on with reasonable promptness;
- Their Medicaid is suspended;
- Their services are reduced;
- Their Medicaid case is closed;
- Their services are changed to be more restrictive; or
- They think DHHS's action was erroneous.

Applicants and beneficiaries may appeal these actions by submitting a request for a fair hearing. If the action being appealed was an action from a managed care organization, beneficiaries should submit an initial appeal to their managed care organization before submitting an appeal to DHHS.

2.6 Confirming Beneficiary Eligibility

Before providing services, verify your patient's Medicaid coverage. Check for a Medicaid managed care plan, Medicare, or any third-party insurance. Ask to see the patient's Nebraska Medicaid ID card.

You can verify Medicaid coverage four ways:

1. Call the Nebraska Medicaid eligibility system (NMES) line at 800-642-6092 (or 402-471-9580 in Lincoln).
2. Work with your electronic data interchange (EDI) clearinghouse to set up an electronic Health Care Eligibility Benefit Inquiry (ASC X12N 270/271)

3. Access beneficiary eligibility online. Separate login IDs and passwords are required for each person accessing the site. More information and enrollment forms are on the internet access for providers webpage on the DHHS website.
4. Call the Medicaid claims customer service at (877) 255-3092 or (402) 471-9128.

2.7 Dual-Eligibles (Medicare and Medicaid Coverage)

Some Medicaid beneficiaries also have Medicare coverage. These individuals are sometimes referred to as “dual-eligibles,” as they are eligible for both programs at the same time. Some individuals qualify for both Medicare and full Medicaid benefits. For others, Medicaid simply covers the costs of Medicare-related expenses like monthly premiums.

If a provider provides Medicare-covered services to dual-eligible beneficiaries, Medicare must be billed primarily, and Medicaid will pay secondarily. Medicare will automatically send (“crossover") claims to Medicaid for processing and payment of coinsurance and deductible. Do not directly send Nebraska Medicaid a claim unless the service provided is one that is never covered under Medicare, but is covered by Medicaid.

2.8 Prohibition on Billing Medicaid Members

Per state regulations at Title 471 NAC 3, providers participating in Nebraska Medicaid agree to accept payment from DHHS as payment in full. The provider will not bill the patient for Nebraska Medicaid-covered services if the claim is denied by DHHS for lack of medical necessity or for failure to follow a procedural requirement.

It is not a violation of state regulations for the provider to bill the patient for services not covered by Nebraska Medicaid. Similarly, it is not a violation of state regulations for a provider to bill the patient for services when it is determined the patient has received money from a third-party resource and the money was designated to pay medical bills. If the patient agrees in advance in writing to pay for the non-covered service, the provider may bill the patient.

2.9 Retroactive Eligibility

Some Medicaid beneficiaries may qualify for retroactive eligibility, meaning they can be found eligible for Medicaid in months prior to the month when they apply for coverage. This retroactive coverage may cover medical bills the beneficiary incurred in the months when they are found retroactively eligible. It is your patient’s responsibility to inform you if they have retroactive Medicaid coverage that they would like to use in order to cover medical bills owed to your office.

More information about retroactive Medicaid is available in state regulations at Title 477 NAC 4.

3. Provider Enrollment

3.1 Overview of Enrollment Requirements

All providers are required to enroll with Nebraska Medicaid before they are eligible to bill for providing covered services, regardless of the delivery system, whether it is fee-for-service, managed care organizations, or waivers.

Nebraska is an "any willing provider" state. This means that the terms and conditions in policies, contracts, or agreements for Nebraska Medicaid providers must ensure equal opportunities, avoiding discrimination against any providers. As a result, providers who meet the necessary qualifications and are willing to comply with the requirements can participate and offer their services.

To be eligible to participate in Title XIX (Medicaid), Title XXI Children's Health Insurance Program (CHIP), and any 1915(c) Medicaid Waiver the provider must meet the general standards for all providers in 471 Nebraska Administrative Code (NAC) Chapters 1, 2, and 3, if appropriate, and the standards for participation for each provider included within:

- Each provider-specific chapter of Title 471 NAC.
- Title 480, 403, and 404 NAC, respectively, for Home and Community-Based Waiver Services (HCBS).
- Title 482 NAC for Managed Care Services.

3.2 Enrollment Requirements

Providers who wish to enroll with Medicaid must begin by contacting Nebraska Medicaid Provider Relations through the Nebraska Provider Data Management System (PDMS), which is connected to our contractor, Maximus (https://www.nebraskamedicaidproviderenrollment.com/Account/Login.aspx?ReturnUrl=%2f).

Providers interested in providing Medicaid Personal Assistance Services (PAS) or Home and Community-Based Services (HCBS) for the Aged and Disabled (AD) Waiver, the Traumatic Brain Injury (TBI) Waiver, the Comprehensive Developmental Disabilities (CDD) Waiver, the Developmental Disabilities Adult Day (DDAD), or Family Support Waiver (FSW) DHHS.DDDcommunitybasedservices@nebraska.gov have preliminary steps to complete before they can enroll with Provider Relations via Maximus. Providers will need to contact these programs directly.

Providers interested in providing Non-Emergency Medical or Non-Medical Transportation services should contact the Nebraska Public Service Commission before enrolling with Provider Relations via Maximus. Providers must obtain certification or an exemption before they are allowed to provide transportation services. Providers can contact the Nebraska Public Service Commission in the following ways:

- By phone: (402) 471-3101, Toll-Free: 1-800-526-0017, TDD: 771,
- Email: PSC.General@Nebraska.gov, or
- Mail: 1200 N Street, Suite 300, Lincoln, Nebraska 68508

Providers interested in enrolling as a Skilled Nursing Facility, Hospital, Lab, Federally Qualified Health Center (FQHC), Home Health, or Hospice Agency must first enroll in Medicare before Medicaid.

Providers must enroll all business locations where services are provided.

Providers must meet all the requirements for a service prior to enrolling.

A provider can be partially approved, meaning they can offer some of the services they requested to enroll in, but not all, if specific service requirements are not met.

3.3 Provider Agreements

The Provider Agreement process includes several documents that must be acknowledged and completed.

All providers must agree to adhere to the terms of the Division of Medicaid and Long-Term Care Service Provider Agreement (MC-19)

- By acknowledging the agreement, a provider agrees to comply with all provisions stated therein.
- A Service Provider Agreement (MC-19) is not an employment agreement or contract, and enrollment as a Medicaid provider does not constitute employment by or with DHHS and does not guarantee referrals.
- Service Provider Agreement (MC-19) cannot be transferred to any other person or entity.
- Every agency provider and independent provider must have their own agreement.
- Providers must enroll all business locations where services are provided.
- The Service Provider Agreement (MC-19) must be revalidated every five years to ensure ongoing compliance and quality.

HCBS providers must sign a Provider Agreement Addendum (MC-190) every year.

All providers must complete and accept the following:

- Ownership Disclosure Acknowledgement.
- Provider Release of Information Felony/Misdemeanor Statement
- “United States Citizenship Attestation form”
- MS-84 “State of Nebraska ACH/EFT Enrollment form”

Certain providers of medical transportation services must also complete the service provider agreement form as indicated in Titles 473 and 474 NAC.

DHHS may require a provider to periodically complete a new service provider agreement to reflect changes in information or eligibility and may terminate the enrollment of a provider that fails to comply with this requirement.

3.4 National Provider Identifier (NPI)

The NPI is a 10-digit number used to identify providers whose services are directly related to an individual’s health, including all payers, in all HIPAA standard transactions. Providers need an NPI before enrolling with Nebraska Medicaid. There are two types of NPIs:

- Type 1 is for individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
- Type 2 is for agencies and organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself (Type 1) and an NPI for your corporation or LLC (Type 2).

Organizations must determine if they have “subparts” that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization's health care provider that furnishes health care and is not itself a separate legal entity**.**

All claims to Nebraska Medicaid for payment for items and services that are ordered, rendered, or referred must contain the National Provider Identifier (NPI) of the physician or other professional who ordered, rendered, provided, or referred each item or service.

3.5 Provider Types

Individual or Independent providers are independent contractors and not employees of DHHS or the State of Nebraska. For the Federal Insurance Contribution Act (FICA)

withholding for Social Security and Medicare taxes, the provider is considered an employee of the beneficiary.

Characterization of an individual or independent provider:

- Individual or sole proprietorship
- Type 1 (Individual) NPI
- Uses an individual social security number
- No employees or subcontractors
- Serves only a limited number of patients
- Files a tax return as an individual
- Reports events to the patient's Services Coordinator (SC)
- Use the electronic visit verification (EVV) system to schedule and report single caregivers.
- Does not meet all the requirements of an agency provider.

Agency providers are registered businesses or organizations that perform administrative tasks, such as recruiting, training, screening, and managing qualified staff according to state and federal regulations. In order be considered an agency provider, an organization must:

1. Be registered with the Secretary of State in one or more states as one of the following:
    - Partnership
    - Corporation
    - Limited Liability Company
2. Have a Type 2 NPI for business and a Type 1 NPIs for each caregiver or service rendering provider.
3. Have an Employee Identification Number.
4. Have a minimum of three permanent employees. This includes:
    - One managing employee or owner who is responsible for essential operational functions such as human resources, payroll, and scheduling
    - Two caregivers who are consistently scheduled and available to provide care.
5. Hire with employment agreements or contracts and maintains employee files.
6. Maintain documentation of employee or contractor payments that can be submitted upon request.
    - This includes forms such as IRS Form 1096, which proves the issuance of at least one Form 1099; IRS Form W-3, which verifies the issuance of at least one Form W-2; or other proof of payment.
7. Collect employment-related taxes and submit them to the appropriate entity.
8. Report on employee payments to the Department of Labor.

9. Pay overtime to employees who work more than 40 hours in a work week.
10. Have an active website with business addresses and contact information.
11. Maintain a business office location that accepts walk-ins and has posted business hours.
12. Review staff and employees against required screenings and maintain records of those screenings.
13. Develop and implement standardized policies and procedures that address specific issues. This includes:
    - Hiring practices and screening of applicants
    - Ongoing screening of employees
    - Documentation and reporting of events
    - Regular caregiver training
14. Use the Electronic Visit Verification (EVV) system to schedule for multiple caregivers and to manage the submission of visits for claiming reimbursement if necessary.
15. Maintain the documentation of services provided for all beneficiaries and by all providers.
16. Regularly receive referrals from DHHS, accept new patients, and provide care for multiple patients.
17. File taxes as an organization.

3.6 Enrollment Process

The Nebraska Provider Data Management System (PDMS), Maximus, uses all the information submitted by the provider, verifies the license, any certifications, and runs the Federal and State Screenings.

Any providers needing fingerprint-based background checks, document review, or any other additional scrutiny are sent to Nebraska Medicaid Provider Relations for state review. Provider Relations reviews all high-risk providers and any other provider with missing or indeterminate information or documents.

Once the background check is received and all other requirements are checked, the state review is completed. The enrollment process is referred to Maximus for a site visit, if needed, and the assignment of a Medicaid ID.

The state may deny the enrollment of an applicant during any part of the process. Applicants are notified about application decisions in writing, and they may appeal a denial within 90 days of denial or submit additional information to comply with the requirements.

3.7 Federal Enrollment Requirements

Section 6401 of the Affordable Care Act lists certain Medicaid provider screening and enrollment requirements that states must follow. The requirements can be found in 42 CFR § 455 Subpart E. Nebraska Medicaid providers must follow these requirements to comply with state and federal laws.

Failure of the provider or owner, as applicable, to pass or complete the following enrollment requirements will result in the denial or termination of the service provider agreement.

3.7.1 Licensure

All provider licenses must be verified to ensure the following:

- Compliance with the laws of the issuing state,
- Alignment with Nebraska laws,
- Remain valid,
- Not expired, and
- Free of any limitations required by state regulations.

3.7.2 Application Fee

The current application fee amount can be found online at https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do#headingLv1

Institutional and Agency Providers must pay the Provider Enrollment Application Fee when submitting applications for the following reasons:

- Initial Enrollment
- Revalidation
- Change of Information - Adding Practice Location
- Change of Ownership - Buyer not accepting assignment of current Provider Agreement

All DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) suppliers (including physicians and non-physician practitioners) are required to pay the application fee for:

- New Applications

    - If the reason for the new application is to change the information on the existing enrollment, and not to add a practice location, then the provider is not required to pay the application fee.
- Enrolling at an additional location
- Revalidations
- Reactivations, unless the deactivation was a result of non-submission of claims for four consecutive quarters.

If the provider is already enrolled in Medicare or has paid the fee to Medicare or another state's Medicaid or Children's Health Insurance Program (CHIP), and can supply documentation of payment, then they are exempt from paying the fee to Nebraska Medicaid.

Providers who are enrolled in Medicare but have not yet established a record in the Provider Enrollment, Chain, and Ownership System (PECOS) may be required to submit an Initial Enrollment application to establish a record in PECOS before they are exempt.

Individual physicians and non-physician practitioners are exempt from paying the application fee.

Providers or categories of providers that have received an application fee waiver from the Centers for Medicare and Medicaid Services (CMS) are exempt from paying the fee. Providers may request a waiver of the application fee. The waiver request should be submitted along with the Service Provider Agreement (MC-19) and must include sufficient detail for Nebraska Medicaid to determine if a waiver is appropriate. As applicable, suggested information to include:

- A narrative describing why payment of the fee would be a hardship,
- The number of Medicaid beneficiaries you expect to serve,
- Documentation that you are in an underserved area or if the service you provide is specialized and not readily available by other providers.

If the waiver is approved by Nebraska Medicaid, it must be forwarded to CMS for a final determination as to whether the application fee will be waived.

CMS criteria for determination: Hardship exceptions should not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Screening and enrollment activities will not begin until the fee is paid or waived.

3.7.3 Risk Levels

All providers are screened according to their assigned risk level - Limited, Moderate, or High. The levels are based on the risk each provider type poses for committing fraud, waste, or abuse against the Medicaid program and its participants.

CMS determines risk levels for some provider types. Nebraska Medicaid determines the risk level for all other providers and can raise the risk level based on the state's experience with the type of provider.

A provider's risk level can change due to reactivation after a termination.

If a provider fits into more than one risk level, the highest screening level is applicable.

Providers enrolled with the Nebraska Medicaid program are responsible for screening their staff based on the services they provide and the assigned risk level.

Limited-Risk Federally Required Screenings

- Verification that a provider meets any applicable federal regulations or state requirements for the provider type.
- Primary source verification of any required licenses, including State licensure verifications in States other than where the provider is enrolling.
- All required federal and state databases are checked at least monthly.
    - Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) is updated monthly.
    - The U.S. government's System for Award Management (SAM) exclusion list is updated daily.
    - Nebraska Medicaid Excluded Providers (NMEP) list.

Moderate-Risk Federally Required Screenings

- Everything mandated for limited-risk providers.
- Unannounced pre- and post-enrollment site visits.

High-Risk Federally Required Screenings

- Everything mandated for moderate-risk providers.
- Fingerprint-based Criminal Background Checks (FCBC) by the Nebraska State Patrol of the provider and any person with 5% or more direct or indirect

ownership control. FCBC must be submitted within 30 days of a request from CMS or Nebraska Medicaid.

3.7.4 Database Checks

All Medicaid providers (including any person with an ownership or control interest or who is an agent or managing employee of the provider) will be checked against federal and state databases during enrollment, monthly, and at revalidation by the Medicaid Provider Relations department using the Nebraska Provider Data Management System (PDMS), connected to Maximus in alignment with the regulated timelines.

The U.S. government's **System for Award Management** (**SAM**) exclusions database screening is required at least once a month.

The SAM exclusion list is updated daily. It is a database of individuals and entities that are disqualified from receiving federal contracts, subcontracts, and financial or non-financial benefits. It contains information on individuals and entities that have been debarred, suspended, or otherwise deemed ineligible to participate in federal programs and contracts. Its primary purpose is to ensure only eligible entities receive federal funding and contracts, helping to protect against fraud and mismanagement.

The **Office of Inspector General's** (**OIG**) List of Excluded Individuals/Entities (LEIE) screening is required at least once a month.

The OIG list is updated monthly. It is a database of individuals and organizations that are prohibited from participating in federal health care programs.

Nebraska Medicaid Excluded Providers (**NMEP**) screening is required at least once a month.

The NMEP list is a database of all providers currently excluded (terminated or suspended) from participating in Nebraska's Medicaid programs.

Questions regarding the Nebraska Medicaid Excluded Providers list can be sent to DHHS.MedicaidProgramIntegrity@nebraska.gov.

All providers are required to screen all facilities, providers, employees, and contractors not screened by Maximus against the exclusion lists SAM, OIG, and NMEP every month.

Medicaid prohibits payment to any person or entity included on an exclusion list. Anyone who hires an individual or entity who has been excluded from participation in Medicaid may be subject to penalties, including fines, sanctions, exclusion from federal healthcare

programs, and even criminal charges for the employer.

3.7.5 Criminal Background Checks

As a condition of enrollment, providers must consent to criminal background checks, including fingerprinting when required to do so under State law or by risk level determined for that category of provider. Failure to consent to criminal background checks will result in the denial or termination of the Service Provider Agreement.

When a provider submits enrollment in the Nebraska Provider Data Management System (PDMS), it is linked to our contractor, Maximus, where it undergoes a risk level assessment.

If the provider is enrolling in a high-risk service or has other considerations that require a Criminal Background Check, the file will be referred to Nebraska Medicaid Provider Relations, who will notify the state patrol and send out a packet for the provider to use: Provider Screening Guidelines.

Any high-risk service provider, or any person with a five percent or more ownership interest in a high-risk service provider, must submit a set of fingerprints, in a form and manner determined by the State Medicaid agency, within 30 days upon request from the Centers for Medicare and Medicaid Services (CMS) or the State Medicaid agency.

3.7.6 Driver's License Checks

Providers who transport beneficiaries must follow the minimum driver standards below:

- At least nineteen years of age or an emancipated minor.
- Possess a current operator's permit issued by any state.
- Knowledge of Nebraska state and local traffic rules and the rules of the road.
- No more than three (3) points assigned against their driver's license.
- Not smoke in the vehicle.
- Competent to conduct the service carefully and dependably.
- Not use illegal drugs.
- Not aware of any mental or physical limitation that would impose a threat to the health or well-being of the passengers.

These standards align with those set by the Nebraska Public Service Commission for DHHS contractors and like agencies, as detailed in Title 291 NAC 3.

3.7.7 Site Visits

CMS and Nebraska Medicaid have the authority to perform site visits on all providers. CMS, its agents, its designated contractors, or Nebraska Medicaid will complete unannounced pre- and post-enrollment site visits of “moderate” or “high” risk providers.” All enrolled providers must permit on-site inspections of and all provider locations. These inspections are required at initial enrollment, revalidation, and when adding a new location, and as needed.

The purpose of a site visit is to verify if the information submitted to Nebraska Medicaid is accurate. Conducting unscheduled and unannounced pre-enrollment site visits helps ensure that prospective providers meet enrollment requirements. Additionally, for revalidations, site visits are a reliable and effective tool to ensure that current providers remain operational and continue to meet required provider standards.

Visits are conducted during normal business hours, 9 am – 5 pm or posted business hours. Exceptions can be made to schedule site visits for mobile units or providers who report open by appointment only. Private residences reported as practice locations will be visited, unless listed as a home address used solely for telehealth.

Visits can be an external or internal review, by an inspector, with limited disruption to business. During the visit, photographs of the business may be taken.

3.8 Approval and Enrollment

Medicaid Provider Relations will review and screen each submitted service provider agreement, and upon approval of the enrollment, will assign an effective date to the provider and a Medicaid provider number to use when billing Medicaid.

3.9 Retroactive Date Requests

HCBS providers, including all waiver service providers, are not eligible to request retroactive enrollment dates. The effective date reflects when all requirements are fulfilled.

Providers who are not HCBS providers may request a retroactive enrollment date.

- Requested effective dates 180 days or more in the past are considered a retroactive date request and must be approved by Nebraska Medicaid Provider Relations.

- Retroactive date requests must include a Medicaid Provider Retroactive Enrollment Effective Date Application (MLTC-99) detailing the circumstances beyond the provider's control that delayed the submittal.
- Medicaid Provider Relations will determine whether the circumstances were beyond the provider's control based on documentation submitted by the provider.

3.10 Renewal/Annual Screening

Nebraska regulations require HCBS providers to renew the Division of Medicaid and Long-Term Care Service Provider Agreement (MC-19) and Provider Agreement Addendum (MC-190) every year at the same time. During the renewal process, all the provider's information on file with Nebraska Medicaid is reviewed. HCBS providers who do not complete the renewal will not be eligible past their renewal due date.

3.11 Revalidation of Enrollment

Federal regulations require Nebraska Medicaid Provider Relations to revalidate the enrollment of all providers at least every five years. This process involves reviewing and updating all information on file. Revalidation is not complete until a provider receives approval. Providers who do not complete revalidation will not be eligible past their revalidation due date.

HCBS Providers are required to finish the revalidation process before the revalidation deadline. If an HCBS provider does not complete the entire revalidation process by the deadline, their provider agreement will be closed, and the agreement cannot be reinstated. The HCBS provider will need to reapply since HCBS services cannot be backdated. The new effective date will be established based on when the enrollment process is finished.

Once the service provider agreement closes, fee-for-service, managed care, prescription, medical claims, or waiver services provided, referred to, or ordered by the closed provider will not be reimbursed by Nebraska Medicaid or the managed care organizations.

If a non-HCBS provider does not complete the revalidation process by the established deadline, the provider agreement will be terminated. However, if the provider successfully revalidates within six months of the termination date, the agreement may be reinstated without any interruption in enrollment.

At revalidation, Maximus Health Services will conduct a full screening appropriate to your risk level in compliance with regulations, and Medicaid Provider Relations must revalidate the enrollment of all providers every 5 years.

3.11.1 Revalidation Notifications

Providers who are in a revalidation period (within 6 months before the revalidation due date) will be subject to the following process regarding the revalidation of their Medicaid provider enrollment:

- Providers will begin receiving revalidation notifications every 30 days starting 6 months before the expiration of their provider enrollment.
- Providers who make updates to their provider information in Maximus within 6 months of their revalidation due date will be required to complete the revalidation of their provider enrollment as part of that update.
- Screening requirements for high-risk providers involve coordination with other entities for essential background checks, as well as some screenings and fingerprinting. While these processes follow their own timelines, it's important to acknowledge that this can extend the revalidation process. To ensure a smooth experience, providers may find it beneficial to allow the full six months to complete the revalidation requirements.
- All required attestations, updates, group member confirmations (when applicable), and other required actions must be completed in their entirety for the revalidation to be completed.
- If revalidation is not completed (meaning the Service Provider Agreement has been submitted and all required screenings have been completed) by the revalidation date, the provider enrollment will be closed.
- Providers who do not revalidate by their due date must start the enrollment process over and may have a gap in enrollment.
    - This may also have an impact on other agreements, including the electronic trading partner agreement for claim submission and the receipt of Medicaid Remittance Advices.
- Payment for Nebraska Medicaid payer claims will be impacted for providers who do not revalidate by their revalidation due date.

3.12 Disenrollment

To disenroll from Nebraska Medicaid, a disenrollment form must be filled out and submitted to Maximus. Payments will not be made for services rendered after the requested disenrollment date.

This disenrollment form can be found at www.nebraskamedicaidproviderenrollment.com under the Provider Education & Training Resources link

4. Program Integrity

Nebraska Medicaid's Program Integrity Unit works to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, abuse, and incorrect payments from taking place.

When designed and implemented well, program integrity initiatives help to ensure that:

- Provider eligibility decisions are made correctly.
- Prospective and enrolled providers meet federal and state participation requirements.
- Services provided to enrollees are medically necessary and appropriate.
- Provider payments are made in the correct amount and for appropriate services.

Program Integrity works closely with other agencies and teams to accomplish its mission. This includes Provider Relations, survey and certification agencies licensure, state OIG, the state's attorney general, other law enforcement agencies, and the state auditor.

Fraud and abuse are both defined in Medicaid regulations (42 CFR § 433.304 and 42 CFR § 455.2).

- Fraud involves intentional deception or misrepresentation with the intent to obtain services, payments, or other gains illegally. Some examples are:
    - Intentionally billing for unnecessary medical services or items.
    - Billing for services or items not provided.
    - Kickbacks- offering, soliciting, or paying for referrals or incentives for services or items.
- Waste includes inappropriate utilization of services and misuse of resources. Examples are:
    - Duplicating tests when providers do not share information.
    - Seeking care in an emergency department where the same service could be provided in a lower-cost setting like a doctor's office or clinic.
    - Provider establishing a minimum number of hours when patient assessments or service authorizations indicate that the patient's needs fall below that minimum.
- Abuse includes taking advantage of loopholes or bending the rules, such as improper billing practices. Such as:

- Billing for unnecessary services or Items.
- Overcharging for services, or misusing billing codes.
- Providing false information to qualify for benefits.
- Unqualified individuals providing services.

Program Integrity uses many tools to identify and address fraud and abuse in the Medicaid program. Specific methods can include:

- Data mining to identify possible fraud and abuse for further examination.
- Audits to determine compliance with federal and state rules and regulations or to identify fraud and abuse.
- Investigations of suspected fraud and abuse.
- Enforcement actions (e.g., provider termination, provider exclusion) against those who have committed fraud.
- Technical assistance and education for state staff so they can prevent and identify fraud and abuse.
- Outreach to and education of the provider and enrollee communities (e.g., how to report suspected fraud, explaining Medicaid rules and requirements).

Many oversight activities focus on identifying and recovering improper payments made to providers, such as payments that should not have been made or that were made in an incorrect amount. When an improper payment is identified, Nebraska returns the federal share to CMS.

4.1 General Requirements for All Services

Providers must be enrolled in Medicaid for the service provided, ordered, referred to, or rendered to be covered.

All services and supplies must meet the definition of medical necessity to be covered.

Employees of DHHS, its subdivisions, and contractors, except clinical consultants, may not serve as providers under Medicaid or as paid consultants to enrolled providers without the express written approval of the Medicaid Director.

4.2 General Records Requirements for All Services

Nebraska law requires that providers keep detailed records of all goods or services related to claims or payments for six years after receiving payment. Anyone who fails to keep or destroys records within six years of receiving payment for a claim could face damages up to three times the amount of that claim.
[Nebraska Revised Statute 68-939]

State and federal regulations require providers to provide all records when requested for an audit. Complete documentation contains, at a minimum, the service provided, the number of units, the service rendering provider, the date that the service was provided, and all additional details relevant to the service.

Claims submission by a provider certifies that the services were provided as billed, were necessary for the patient's condition, and are completely documented in the patient's clinical record.

All requested materials should be supplied by the indicated deadline. If the requested documentation is not provided for review, or the documentation that is provided is found to be insufficient to support the service that has been billed, the Nebraska Medicaid program will request refunds from the provider.
The provider's failure to properly document services rendered to Medicaid beneficiaries, including Medicaid waivers, and CHIP recipients may constitute a violation of the False Medicaid Claims Act. The matter may result in a refund request, sanctions imposed by DHHS, or a referral to the Medicaid Fraud and Patient Abuse Unit of the Nebraska Attorney General's office.

Due to the Health Insurance Portability and Accountability Act (HIPAA) and Medicaid privacy laws, many providers worry about the legitimacy of record requests; if a provider is unsure about a request's legitimacy, reach out to the Nebraska Medicaid Program Integrity. DHHS.MedicaidProgramIntegrity@nebraska.gov

Reporting Lost or Damaged Records

In accordance with Nebraska Medicaid Regulations (471 NAC 3-003.02 #5, 3-002.01 #5, 2-001.03 #7), Medicaid providers are required to maintain documentation of services and to supply them upon request. Failing to supply records when requested is grounds for sanctions to be imposed against the provider (471 NAC 2-002.03(6).

Providers are encouraged to report lost or damaged records as soon as the loss or damage is known to the provider. To report lost or damaged records, providers should complete form MLTC-10 Lost or Damaged Records Attestation and submit it to: DHHS.MedicaidProgramIntegrity@nebraska.gov

4.3 Disclosure of Information by Providers

Federal regulations require providers to submit the following information and to update the information with Provider Relations through the Nebraska Provider Data Management System (PDMS) portal, Maximus, within 35 days of any changes:

- Ownership and control- For each managing employee, person or entity with an ownership or control interest in the provider, and subcontractor of which the provider owns at least five percent, a provider must disclose the following:
  - Legal name,
  - Address, including, as applicable, the primary business address, every business location, and P.O. Box address,
  - Date of birth or incorporation,
  - Tax Identification Number or social security number as applicable,
  - Whether anyone is related to another as spouse, parent, child, or sibling, and
  - The name of any other disclosing entity in which a person has an ownership or controlling interest.
- Changes in contact information (address, phone number, etc.)
- Changes in the services offered
- Updates to licenses or certifications

DHHS may refuse to approve a service provider agreement, terminate a service provider agreement, or suspend payment if a provider fails to disclose ownership or control information.

The service provider agreement may be terminated if the provider does not comply with the Federal 35-day notification requirements.

4.4 Potential Consequences of Fraud, Waste, or Abuse

Potential consequences of fraud, waste, or abuse include:

- Criminal investigation and/or prosecution
- Civil monetary penalty
- Exclusion from OIG, Medicare, and/or Medicaid permanently or for a period of time
- Referral to professional licensing board
- Payment suspension
- Recoupment of Medicaid overpayment
- Peer review
- Education
- Other administrative remedies.

4.5 Termination or Denial of Enrollment

Medicaid Provider Relations may deny enrollment, and Provider Integrity may terminate the enrollment of any provider for the following reasons:

- Where any person with a 5 percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider:
    - Does not submit timely and accurate information or cooperate with any screening methods required.
    - Has been convicted of a criminal offense related to that person's involvement with Medicare, Medicaid, or CHIP program in the last 10 years.
    - Is terminated under the Medicaid program or CHIP of any other State and is currently included in the termination databases.
    - Fails to submit timely or accurate information
    - Fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a State Medicaid agency request.
    - Fails to permit access to provider’s locations for any site visits.
- If it is determined that the provider has falsified any information provided on the application.
- If the identity of any provider applicant cannot be verified.

Any provider's employees are subject to the same standards as owners or managing employees.

4.6 Self-disclosing Provider Fraud

Providers can self-disclose issues on form MLTC-61. Self-disclosure offers providers the opportunity to minimize the potential cost and disruption of a full-scale audit and investigation and to negotiate a fair monetary settlement. Self-disclosure will not absolve the provider of criminal or civil culpability. If a law enforcement agency determines that a crime was committed, any information shared with DHHS will be forwarded to the appropriate agency.

4.7 Reasons for Denials or Administrative Sanctions

Program Integrity, in its discretion, may deny enrollment or sanction a provider based on the reasons outlined in regulations. To ensure compliance and uphold standards, providers are encouraged to review 471 NAC 2.005.01 and align their practices accordingly.

4.8 Sanctions and Exclusion

Program Integrity may impose sanctions against a provider or any person employed by or contracted with the provider entity responsible for a violation.

Provider sanctions include:

- Terminations from participation in:
  - The Medicaid program
  - Managed Care
- Suspension or withholding of payments
- Recoupment from future payments
- Closed-end service provider agreement
- Provider education
- Exclusion of a non-enrolled individual, affiliate, owner, managing employee or other individual or entity from participation

4.9 Termination from Participation

When terminated, the provider may be subject to one or more of the following types of exclusions:

- Emergency, which is an immediate exclusion based on DHHS's determination that patient health and safety may be at risk.
- Time-limited, which is an exclusion for a designated time.
- Technical, which is based on a provider's failure to meet a standard or requirement and remains in effect until DHHS determines the provider meets the standard or requirement.
- Permanent exclusion.

DHHS must deny or terminate the enrollment of a provider that has been excluded or terminated from participating in Medicare or Medicaid, or the Children's Health Insurance Program (CHIP) in another state.

4.10 Conditions of Termination and Exclusion

Nebraska Medicaid notifies the general public when an individual or an entity has been excluded from Medicaid participation by including their name on the Nebraska Medicaid Excluded Providers (NMEP) list. The list is posted on the Nebraska DHHS website.

Termination or exclusion from participation disqualifies a provider from submitting claims for payment, either personally or through any clinic, group, corporation, or other association, to DHHS for any services or supplies provided under Medicaid, except for those services or supplies provided before the termination or exclusion.

Excluded persons or entities are not allowed to submit claims for payment either directly or through any clinic, group, corporation, or other association for any services provided, ordered or referred by that person or entity. If any claims are submitted, civil penalties could be imposed, or criminal prosecution could occur.

Excluded people or entities are also prohibited from associating with an enrolled provider. Providers that submit claims for individuals on the excluded provider list may be subject to refunds, sanctions, or a referral for investigation from Nebraska Medicaid.

Providers should check the NMEP list for all new hires and at least monthly for all staff.

Individuals and entities are listed on the NMEP list for the duration of their exclusion. To confirm an individual or entity on the list, send an email with the name, date of birth, and last four of their social security number to Program Integrity DHHS.MedicaidProgramIntegrity@nebraska.gov

Listed parties may request reactivation as a provider or removal from the NMEP list after the period of exclusion has expired. Providers wanting to reactivate participation as enrolled providers with Nebraska Medicaid may initiate the NMEP removal process by

submitting a new Service Provider Agreement through Maximus at www.nebraskamedicaidproviderenrollment.com.

Reactivation is subject to DHHS's discretion and is decided in part based on history and an assessment of risk factors. DHHS may grant reinstatement only if there is a reasonable certainty that the actions that led to the original exclusion have not been repeated and are not expected to happen again. In making this determination, DHHS will consider, in addition to any factors outlined in State law:

- The actions of the person or organization that took place before the notice of exclusion, if not known to the agency at the time of the exclusion.
- The conduct of the individual or entity after the date of the notice of exclusion.
- If all fines, and debts due and owed (including overpayments) to any Federal, State, or local government related to Medicare, Medicaid, or any State health care programs have been paid, or satisfactory arrangements have been made, that fulfill these obligations.

A request to be removed from the NMEP without reactivating enrollment can be done by submitting the Nebraska Reactivation Questionnaire: http://dhhs.ne.gov/Documents/Nebraska%20reactivation%20questionnaire.pdf to Program Integrity at DHHS.MedicaidProgramIntegrity@nebraska.gov. Removal from the NMEP list is at the discretion of DHHS.

4.11 Provider Screening Guidelines

The background check screening guidelines can be found at https://dhhs.ne.gov/Documents/Provider%20Screening%20Guidelines.pdf.

This document is used as a guide when conducting the Nebraska Data Exchange Network (NDEN) and Fingerprint-based Criminal Background Checks (FCBC) criminal history screenings. The offenses listed are based on 42 CFR § 424.535, Revocation of Enrollment in the Medicare Program, and other federal guidance, including the OIG Exclusion Authorities, and the Social Security Act Sec. 1128.

DHHS must deny or terminate the enrollment of a provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with a Medicare, Medicaid or Title XXI program within the last 10 years, unless DHHS determines that denial or termination of enrollment is not in the best interest of the Medicaid program.

4.12 Payment Error Rate Measurement (PERM)

The Payment Integrity Information Act (PIIA) of 2019 requires the heads of Federal agencies to perform an annual assessment of the programs they manage, identifying any that might be vulnerable to significant improper payments. They must estimate the extent of these improper payments, submit those estimates to Congress, and deliver a report on the steps the agency is taking to minimize improper payments.

These requirements are implemented through the federal Payment Error Rate Measurement audit every 3 years.

Providers wondering if a record request is related to this audit can reach out to Program Integrity at DHHS.MedicaidProgramIntegrity@nebraska.gov for verification.

4.13 Reporting Provider Allegations

Concerns regarding potential provider fraud, waste, abuse or error can be submitted via an online form at https://mltcmpi-dhhs.ne.gov/ or emailed to DHHS.MedicaidProgramIntegrity@nebraska.gov.

Concerns regarding the abuse, neglect, or exploitation of an individual by a provider are reported to the Abuse and Neglect hotline 1- 800- 652-1999 or via the online form at https://neabusehotline-dhhs.ne.gov . If the person is in immediate danger, call 911.

4.14 Provider Education

The Program Integrity web page includes informational materials developed by state staff and the federal government for providers: https://dhhs.ne.gov/Pages/Program-Integrity.aspx

5. Billing for Services and Rates

5.1 Fee for Service Claims

This section provides an overview of the Fee-For-Service (FFS) claims and adjustments process for providers serving beneficiaries assigned to FFS coverage. It outlines the steps for submitting claims and adjustments via paper or electronic methods, the review and payment procedures, and available resources for billing guidance and claim status inquiries. Detailed instructions tailored to specific claim types and programs will be provided in subsequent chapters to assist providers in accurate claim submission and processing.

Beneficiaries eligible for Medicaid coverage may be enrolled under either a managed care organization (MCO) or fee-for-service (FFS) program. This section addresses claim submission procedures specific to beneficiaries assigned to fee-for-service coverage. Providers should follow the instructions outlined below when submitting claims for services rendered.

5.1.1 Submittal (Paper/Electronic)

Providers may submit claims for services rendered either electronically or on paper. To be considered for payment, all claims must be submitted within six months from the date of service. Claims submitted after this timeframe may be denied, unless an exception applies based on program-specific guidelines or a case-by-case review.

Paper Claim Submissions

Providers must use the appropriate paper claim form based on the type of service provided:

- **CMS-1500** – For professional services
- **CMS-1450 (UB-04)** – For institutional services
- **ADA Dental Claim Form** – For dental services

Once completed, paper claims can be submitted by **mail** or **fax** to the following address:

Department of Health and Human Services – Medicaid Claims
P.O. Box 95026
Lincoln, NE 68509-5026
Fax: 402-742-1197

Ensure that all information on the form is complete, accurate, and legible to avoid delays in processing.

Electronic Claim Submissions

Providers submitting claims electronically must be properly enrolled to do so. This includes completing the **MS-85** and **MS-86** forms, which can be found here: https://dhhs.ne.gov/Pages/Electronic-Data-Interchange-Partner-Enrollment.aspx

Electronic claims must be submitted in one of the following standard HIPAA-compliant formats, depending on the service type:

- **837P** – For professional claims
- **837I** – For institutional claims
- **837D** – For dental claims

All electronic claims must meet Nebraska Medicaid's formatting and data requirements to be accepted for processing. It is recommended that providers work with a certified clearinghouse or billing software vendor to ensure compliance.

Claims must be submitted within six months from the date of service to be considered for payment. Late submissions may be denied unless an exception applies, which may be determined based on program-specific considerations or case-by-case review.

5.1.2 Claim Review

Once a claim is received, it will undergo a series of processing steps. If any issues are identified, the claim may be flagged for edits and routed to a payment reviewer for further evaluation. The reviewer has the authority to approve payment, deny the claim, or delete it as necessary. If no issues are found during processing, the claim will automatically pass through the system and be paid without manual intervention.

5.1.3 Payment

When a claim is approved for payment, the corresponding payment is typically issued on the Tuesday following the claim's submission. Please note that this schedule may vary due to **state-observed holidays**.

If a claim is not approved for payment, providers will receive either a Remittance Advice or an Electronic Claim Activity (ECA) report outlining the details and results of the claim processing.

5.1.4 Billing Guidance

Billing guidance is specific to each individual claim type and program. Providers should follow the general steps outlined in this section for submitting claims and adjustments.

5.1.5 Checking Claims Status

Providers have two options for checking the status of their claims with the State of Nebraska:

- **Contact the Claims Customer Service Line** – Providers may call 877-255-3092 or 402-471-9128 (select Option 1) to request an update on their claims.
- **Enroll in Internet Access for Online Claim Status** – Providers can register for online access to view claim submissions. Detailed information about this option is available at: https://dhhs.ne.gov/Pages/Medicaid-Provider-Internet-Access.aspx

5.1.6 Customer Service Information

For assistance with Nebraska Medicaid claims, providers may contact the Medicaid Claims Customer Service team by calling **877-255-3092 (Option 1) or 402-471-9128 (Option 1).** Inquiries can also be submitted via email to DHHS.MedicaidClaimsCustomerService@nebraska.gov. Representatives are available to assist with claim status, submission questions, and general claims-related inquiries.

5.2 Fee for Service Adjustments

Providers may submit adjustments to previously processed claims in order to correct or update information. Adjustments may only be submitted after the original claim has been paid or denied. Deleted claims cannot be adjusted and must be resubmitted as new claims.

5.2.1 Submittal (Paper/Electronic)

Adjustments may be submitted either electronically or on paper. To be considered for processing, they must be submitted within 90 days of the original claim's payment or denial date. Submissions received after this timeframe may be denied, unless an exception applies based on program-specific guidelines or a case-by-case review.

Paper Adjustment Submissions

Adjustments submitted on paper must clearly include the original claim number. Once completed, paper adjustments can be submitted by mail or fax to the following address:

Department of Health and Human Services – Medicaid Claims
P.O. Box 95026

Lincoln, NE 68509-5026
Fax: 402-742-1197

Ensure that all information on the adjustment form is complete, accurate, and legible to avoid delays in processing.

Electronic Adjustment Submissions

Providers submitting electronic adjustments must be enrolled with a certified clearinghouse and ensure submissions comply with HIPAA standards and Nebraska Medicaid's formatting and data requirements. All electronic adjustments must include the original claim number to be accepted for processing. Working with a certified clearinghouse or billing software vendor is strongly recommended to help ensure proper formatting and successful submission.

Adjustments must be submitted within 90 days of the original claim's payment or denial. Late submissions may be denied unless an exception applies, which may be determined based on program-specific considerations or case-by-case review.

5.2.2 Claim Review

When an adjustment is submitted, it enters the system and is reviewed by a payment reviewer. The reviewer has the authority to approve or deny the adjustment. If approved, the adjustment is marked as paid. If denied, the reviewer will complete a denial notice outlining the reason for denial, which will be sent to the provider pay-to address on file. Should additional issues be identified during further review, the adjustment may be denied again as necessary.

5.2.3 Payment

When an adjustment is approved for payment, the corresponding payment is typically issued on the Tuesday following the adjustment's submission. Please note that this schedule may vary due to **state-observed holidays**.

If an adjustment is not approved, providers will receive a denial notice detailing the reason(s) the adjustment was not accepted or deemed incorrect. This information is intended to assist providers in identifying and resolving any issues for potential resubmission.

5.3 Managed Care and Dual Eligible Special Needs Plan (DNSP)

When billing for services provided to beneficiaries who are enrolled through the Heritage Health MCOs and Dual Eligible Special Needs Plans (DSNPs), providers should refer to the provider manual(s) and billing guidance of the MCO(s) which they're enrolled with and bill according to their contract with the MCO. Provider resources are available for each of the Heritage Health MCOs below:

- **Molina**
  - Provider materials: https://www.molinahealthcare.com/providers/ne/medicaid/resources/provider-materials.aspx
  - Provider services phone number: (844) 782-2678
- **Nebraska Total Care**
  - Provider resources: https://www.nebraskatotalcare.com/providers/resources/forms-resources.html
  - Provider services phone number: (844) 385-2192
- **UnitedHealthcare:**
  - Provider manuals (by state): https://www.uhcprovider.com/en/admin-guides/cp-admin-manuals.html
  - Provider services phone number: (866) 331-2243

5.4 Third Party Liability

Nebraska Medicaid carries out the third party liability (TPL) functions through the Recovery and Cost Avoidance Unit (RCA). The RCA unit is comprised of four separate programs working together to ensure that Medicaid is the payer of last resort for Medicaid covered services. Two programs work to avoid costs prior to Medicaid paying for a covered service, and two programs seek to recover funds after Medicaid has made payment and subsequently learn that there was a liable third party.

Cost Recovery is accomplished through:

Estate Recovery program

When Medicaid recipient passes away, Estate Recovery works with the families, the courts, and attorneys to help recover funds. When a patient is determined eligible for Medicaid, they often have resources which are excluded until their death. Estate Recovery will review available assets, surviving heirs, estate documents, claims data,

and other information to determine the amount the program should receive prior to the distribution of the decedent's assets. See 471 NAC chapter 38 for further detail.

Casualty/TPL program

In some situations, another party is responsible for medical bills because they are legally liable for injuries sustained by a Medicaid recipient. In these cases, Medicaid has the power to subrogate ("stand in the shoes") for the patient and be reimbursed for claims paid which were paid by the agency. Most of the program focuses on recovering from auto and property insurance but can also work with attorneys to resolve settlements in both personal injury and class action lawsuits.

Cost Avoidance is Accomplished Through:

Health Insurance Premium Payment (HIPP) program

Because Medicaid is the payer of last resort, if private health insurance is in force, the insurer must pay for claims before Medicaid does. HIPP asks: "If we pay the premium on the health insurance policy, and the health insurance policy will lessen the amount of money we spend on paying claims, will overall costs be reduced?" When the answer is yes, HIPP can make those payments on health insurance premiums. Program enrollment is limited; most patients need to have access to employer-sponsored health insurance and have high medical needs to be considered. See 471 NAC chapter 30 for further detail.

Coordination of Benefits (COB) Program

COB occurs between health insurers and Medicaid. The COB program team add, verify and maintain the health insurance information of Medicaid-eligible members. They also work with insurance companies to recover payment when appropriate. COB-Long Term Care (LTC) also coordinates with private LTC insurers to recover LTC claims as allowed by State and Federal rules and regulations. See 471 NAC chapter 3 for further detail.

5.4.1 Medicaid as the Payer of Last Resort

The Medicaid Program is the payer of last resort for covered medical services. Federal and state rules require providers to make a reasonable effort to pursue all third-party resources. The provider is responsible for determining whether the member has Medicare or other insurance. Providers must bill Medicare and any other third-party resource before submitting claims to Nebraska Medicaid.

Determining Other Insurance

For FFS members Medicaid coverage can be determined in four ways:

- Call the Nebraska Medicaid eligibility system (NMES) line (instructions).

- Work with your electronic data interchange (EDI) clearinghouse to set up electronic Health Care Eligibility Benefit Inquiry (ASC X12N 270/271)
- Access patient eligibility online. Separate login IDs and passwords are required for each person accessing the site. For enrollment forms, go to internet access for providers.
- Call the Medicaid claims customer service at (877) 255-3092 or (402) 471-9128.

TPL (individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) leads or TPL changes for members in FFS should be reported via the AccessNebraska.gov/report changes function: https://iserve.nebraska.gov/change-in-circumstance.

In addition, providers should question the Medicaid beneficiary to determine if any other health care resources are available for payment. If a discrepancy exists between the Medicaid beneficiary's statement and the verification system; these changes may also be easily reported via the "report changes function": https://iserve.nebraska.gov/change-in-circumstance.

For TPL verification of members assigned to a Heritage Health Managed Care Organization (MCO), providers may report TPL leads or changes for member's health insurance to the member's assigned MCO. Find MCO contacts here.

Payer of Last Resort

Medicaid will not pay for medical services as a primary payer if a third-party resource is contractually or legally obligated to pay for the service. The Nebraska Chronic Renal Disease Program and the Medically Handicapped Children's Program are not included as a third-party resource.

As a Medicaid enrolled provider, you must alert Nebraska Medicaid to a potential third-party resource. The provider must notify the Nebraska Medicaid when a provider receives a request for an itemized bill or a request for the balance of a bill from the patient, an attorney, an insurance company, or an employer. Providers are required to cooperate in securing third-party payments. Nebraska Medicaid 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.

TPL Claims Guidance

Providers must bill all third-party resources and the patient, when there is a share of cost obligation, for services provided to the patient, 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.

Waiver claims are an exception to the payer of last resort requirement. Providers may submit Waiver claims to Medicaid before submitting them 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.

Other insurance coverage paid needs to be listed on the Medicaid claim, whether made to the provider or to the member. If the other insurance coverage denies payment, indicate this on the Medicaid claim form. All documentation of payment or denial shall be submitted with the Medicaid claim. Refer Title 471 NAC chapter 3 for additional details.

When third party payments are received after a claim has been submitted to DHHS, the provider must refund DHHS 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.

For timely filing of claims with other health insurance the provider must secure the right to Medicaid consideration for payment, by filing within 12 months from service date even if the third-party resource has not been resolved. For timely filing of claims with casualty insurance, a provider must submit claims within 24 months of the date of service. For assistance or questions with TPL claim payment providers may contact 877-255-3092 or 402-471-9128.

If a provider enters into an agreement with a Medicaid beneficiary or a representative of the beneficiary to accept less than billed charges, the provider is considered paid in full. No further payment is due from either the beneficiary or Nebraska Medicaid

It is not a violation for a provider to bill the beneficiary for services when it is determined the beneficiary has received money from a third-party resource and the money was designated to pay medical bills.

Please see Title 471 NAC Chapter 3 for more detailed information on billing Medicaid TPL claims.

5.5 Share of Cost (SOC)

A share of cost (SOC) refers to the cost of medical expenses a beneficiary must have during any given month before they receive assistance from Medicaid. This can also be called a “spenddown.” Beneficiaries who are responsible for an SOC are Nebraska Medicaid beneficiaries who do not meet the requirements for traditional Nebraska

Medicaid due to excess income but can demonstrate a medical need based on the Medically Needy Income Level (MNIL).

Many different Medicaid eligible groups whose income is above household limits may have to pay an SOC. These groups can include the aged, blind and the disabled population, low-income parents or families, and those receiving long-term care services and supports which include the Aged & Disabled (AD) or Developmental Disability (DD) waivers.

5.5.1 SOC Documentation

DHHS sends a form each month to each beneficiary with SOC arrangements. The beneficiary's medical providers must fill out and sign the form to demonstrate the beneficiary's monthly medical costs. The medical provider that provides the last service necessary to meet the SOC will submit the completed SOC form as directed on the form. The form is used by DHHS to verify if the beneficiary has paid enough medical expenses during that month to be eligible for Medicaid assistance.

Procedures for Institutionalized Individuals

Beneficiaaries with SOC obligations that are paid to a nursing home, assisted living waiver, or in-home waiver do not receive SOC forms for their healthcare provider(s) to fill out. This is because their monthly obligation is paid directly to their health care or waiver service provider

Coordination of Benefits

When a beneficiary with an SOC obligation has medical insurance (including Medicare, worker's compensation, etc.), the claim for payment must be submitted to the insurance company before consideration for the SOC obligation.

5.6 Fee Schedules

Nebraska Medicaid provider rates and fee schedules are available on the following website: https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx.

For questions regarding provider rates and fee schedules, email dhhs.mltcratesreimbursement@nebraska.gov.