

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

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

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

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

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

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

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

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

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

~~3-002.11 Billing the Client: Providers participating in NMAP agree to accept NMAP's payment as payment in full. The provider shall not bill the client for Medicaid coverable services if the claim is denied by the Department for lack of medical necessity or for failure to follow a procedural requirement (such as prior authorization, claim submission instructions, timely claims filing limits, etc.). The provider shall not bill the client for services covered by NMAP. It is not a violation of NMAP's regulations for the provider to bill the client for services not covered by NMAP. It is not a violation for a provider to bill the client for services when it is determined that the client has received money from a third party resource and that money was designated to pay medical bills. See 471 NAC 3-004.10B, 3-005.05, and 3-004.05F.~~

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

3-002.11 Billing the Client: Providers participating in NMAP agree to accept NMAP's payment as payment in full. The provider must not bill the client:-

1. For the difference between the Medicaid allowed fee paid for a service and the provider's usual and customary charge (balance bill);
2. For services that are considered a cost of doing business (such as fees for missed appointments, no-shows or file reactivation fees); or
3. If the claim is denied by the Department for lack of medical necessity or for provider failure to follow a procedural requirement (such as prior authorization, claim submission instructions, timely claims filing limits, etc.).

It is not a violation of NMAP regulations for a provider to bill the client, if the client agrees prior to receiving the service in writing, for:

1. Services not covered by NMAP;
2. Services that the client receives that exceed coverage limitations in NMAP regulation; or
3. The remaining balance of the Medicaid fee schedule allowable for a service that was not paid in full by Medicaid because the total dollar amount of the client's treatment exceeded the coverage limitations in NMAP regulation.

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

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

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

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

3-003 Billing Requirements

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

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

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

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