G. Claims for payment are to be submitted electronically to Nevada Medicaid's fiscal agent. Refer to Section 108 of this chapter for addresses and other information.

H. It is the provider's responsibility to submit clean, accurate and complete claims to assure accurate payment within Medicaid time frames.

Claims not meeting this criterion will be returned from the fiscal agent to the provider.

I. Nevada Medicaid will neither accept nor reimburse professional billings for services rendered by anyone other than the provider under whose name and provider number the claim is submitted (e.g., a claim for an office visit submitted by a physician when a psychologist or other personnel actually provided the service). Individuals who do not meet Medicaid criteria for provider numbers must not have their services billed as through a physician/dentist to the Medicaid program for payment.

J. Medical residents do not meet Medicaid criteria for provider status. No service provided by a medical resident is to be submitted by another licensed physician/dentist to the Medicaid program for payment except by the teaching physician under the policy guidance in MSM Chapter 600.

K. Payments are made only to providers. (Recipients who provide transportation for themselves and/or other recipients may be reimbursed as providers under certain circumstances.) A provider cannot request payment from Medicaid recipients assuming Medicaid will reimburse the recipient. Optional reimbursement to a patient is a characteristic of the Medicare program, not the Medicaid program.

L. Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of HHS, or the state Medical Fraud Control Unit (MFCU).

M. When payment appears to be unduly delayed, a duplicate billing labeled "duplicate" or "tracer" may be submitted. Failure to indicate "duplicate" or "tracer" may be interpreted as a fraudulent practice intended to secure improper double payment.

Group practices should make certain that rebilling shows the same service codes, the same physician's name and the same Medicaid provider number. If it should be necessary to alter the billing to show different codes or descriptors, a copy of the previous claim should be attached to the revised billing.

105.1A EXTENDED SERVICES

Services or treatment provided over an extended period of time require interim billing so that

claims will be received no later than the stale date:

1. The discharge date or the last day of the month which service was provided, whichever comes first, is considered the date of service for inpatient/residential claims. Each interim monthly billing must be received no later than the stale date.

2. Physicians, individual practitioners, inpatient hospitals, and clinics providing ~~prolonged or~~ services over an extended period of time or that cross over the month into the next month(s) require monthly ~~treatment should submit interim~~ billings for each calendar month~~; e.g., therapists whose services have been prior authorized for several months; and home health agencies authorized for ongoing, long-term care.~~ and need to be received no later than the stale date.

3. A global payment will be paid to the delivering obstetrician when the pregnant woman has been seen seven or more times by the delivering obstetrician and must be billed following the delivery. The delivery date is considered the date of service in this instance. Bill all other obstetrical claims as follows:

    a. Prenatal laboratory panels must be billed before the stale date under rules of clinical laboratory services;

    b. Prenatal visits (three or fewer) must be itemized and submitted before the stale date;

    c. Prenatal visits (four to seven or more) must be billed using appropriate obstetrical codes and submitted before the stale date; and

    d. If delivery is performed by someone other than the prenatal provider, prenatal care is billed as above before the stale date.

105.2 REIMBURSEMENT

Nevada Medicaid reimburses qualified enrolled providers for services provided within program limitations to Medicaid-eligible persons. Reimbursement rates and methodologies are established by the Rates Unit at the DHCFP. Rates and methodologies are based on, but not limited to, federal regulations and fee studies prior to billed charges. Providers may appeal their rate of payment to the DHCFP, submit appropriate documentation and receive administrative review. Refer to Chapter 700 in this manual for specific information.

105.2A LIMITATIONS

1. Medicaid pays global or per diem rates to facilities.

2. Most individual practitioners are paid computer-generated maximum allowable amounts that are the result of multiplying a specific dollar amount times the relative unit value