REIMBURSEMENT POLICY STATEMENT
Nevada Medicaid

Policy Name & Number	Date Effective
Overpayment Recovery-NV MCD-PY-1701	01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject

Overpayment Recovery

B. Background

Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT®/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Retrospective review of claims paid to providers assist CareSource with ensuring accuracy in the payment process. CareSource will request voluntary repayment from providers when an overpayment is identified.

Fraud, waste, and abuse investigations are an exception to this policy. In these investigations, the look back period may go beyond 2 years.

C. Definitions

- **Claims Adjustment** – A claim that was previously paid and is being updated for one of the following reasons:
  - denied as a zero payment
  - a partial payment
  - a reduced payment
  - a penalty applied
  - an additional payment
  - a supplemental payment
- **Coordination of Benefits (COB)** – A payment from another carrier received after a payment from CareSource, and the other carrier is the member's primary insurance.
- **Credit Balance/Negative Balance** – Funds owed to CareSource due to a claim adjustment.
- **Explanation of Payment (EOP)** – Contains payment and adjustment information for claims the provider submitted for payment to CareSource.
- **Forwarding Balance (FB)** – An adjustment that occurs within an EOP to a claim with a prior paid amount. The FB amount does not indicate that funds have been withheld from the provider's payment for this remittance advice. but only indicates that a past claim has been adjusted to a different dollar amount and that funds are owed to CareSource.

- **Improper Payment** – A payment that should not have been made or an overpayment was made. Examples include, but are not limited to the following:
  - payments made for an ineligible member
  - ineligible service payments
  - payments made for a service not received
  - duplicate payments
- **Overpayment** – Any payment made to a network provider by a Managed Care Organization (MCO) to which the network provider is not entitled to under Title XIX of 42 CFR.
  - A claim adjustment is only considered to result in an overpayment when a claim that previously paid is updated to a denied status as a zero payment or results in a reduced payment.
- **Provider Level Balancing (PLB)** – Adjustments to the total check / remit amount occur in the PLB segment of the remit. The PLB can either decrease the payment or increase the payment. The sum of all claim payments (CLP) minus the sum of all provider level adjustments in the PLB segment equals the total payment (Beginning Segment for Payment Order/Remittance Advice [BPR], which means total payment within the EOP).
- **Retroactive Eligibility** – A payment for a member who was retroactively terminated by the state. The member is not eligible for benefits.

D. Policy

I. In accordance with 42 C.F.R. § 438.608, CareSource requires providers to report any overpayment received by the provider. The overpayment must be returned to CareSource within 60 calendar days after the date on which the overpayment was identified, and CareSource must be notified in writing of the reason for the overpayment.

II. CareSource will provide all the following information when seeking recovery of an overpayment made to a provider:
   A. The patient's name, date of birth, and Medicaid identification number
   B. The date(s) of services rendered.
   C. The specific claims that are subject to recovery and the amount subject to recovery, including any interest charges.
   D. The specific reasons for making the recovery for each of the claims subject to recovery.
   E. If the recovery is a result of member disenrollment from the CareSource, the effective date of disenrollment.
   F. An explanation that if a written response to the notice is not received within 30 calendar days from receipt of the notice, the overpayments will be recovered from future claims.
   G. How the provider may submit a written response disputing the overpayment.
   H. How the provider may submit a written request for an extended payment arrangement or settlement.

III. Overpayment Recoveries
   A. Lookback period is 24 months from the claim paid date.
   B. Advanced notification will occur 30 days in advance of recovery.
   C. If the recovery occurs outside of original claim timely filing limits, the corrected claim submission timeframe is 60 days from the date of the recovery. Normal timely filing limits apply to corrected claims being submitted within original claim timely filing guidelines.

IV. Coordination of Benefit Recoveries
   A. Lookback period is 12 months from claim paid date.
   B. Advanced notification will occur 30 days in advance of recovery.
   C. If the recovery occurs outside of original claim timely filing limits, the corrected claim submission timeframe is 60 days from the date of the recovery. Normal timely filing limits apply to corrected claims being submitted within original claim timely filing guidelines.

V. Retro Active Eligibility Recoveries
   A. Lookback period is 24 months from the date CareSource is notified by Medicaid of the updated eligibility status.
   B. Advanced notification will occur 30 days in advance of recovery.

      NOTE: All retrospective reviews must be pre-approved by the Office of Program Integrity. This includes investigations of claims initiated by the Contractor and/or its Subcontractor. The Contractor is allowed a look-back period of a minimum of eighteen (18) months and a maximum of thirty-six (36) months based on the date of service of the claim.

VI. Management of Claim Credit Balances
   A. Regular and routine business practices, including, but not limited to, the updating and/or maintenance of a provider's record, can create claim credit balances on a provider's record. This may result in claim adjustments, both increases and/or decreases in claim paid amounts, and/or forward balancing may move a provider's record into a negative balance in which funds would be owed to CareSource. This information will be displayed on the EOP in the PLB section.
   B. Negative balance status and the associated reconciliation of that balance that is the result of a claim adjustment that increased the claim paid amount is not considered to be an overpayment recovery and does not fall under the terms of this policy.
      1. Claim Adjustment Example
         a. A claim paid $10 previously but was updated to pay $12. The adjustment created a $10 negative balance and paid the provider the full $12 when adjusted, instead of the $2 difference.
         b. The $10 negative balance is not considered to be an overpayment subject to the guidelines outlined in section D.I – D.IV.
      2. Overpayment Example

a. A claim previously paid $12 but is updated to pay $10. The claim adjustment with the $2 reduced payment is subject to the guidelines outlines in section D.I – D.IV.
b. The reduced payment will trigger a 30-day advanced notification with the details related to the claim and overpayment.

C. Reconciliation of negative balance status will be completed through claims payment withholds for otherwise payable claims until the full negative balance has been offset, unless otherwise negotiated.
D. Providers are notified of negative balances through (EOPs) and 835s. Providers are expected to use this information to reconcile and maintain accounts r(AR) to account for the reconciliation of negative balances.
E. Notification of negative balances and reconciliation of negative balances may not occur concurrently.
Providers are expected to maintain AR to account for the reconciliation of negative balances when occurring.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT® codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

CareSource Provider Manual
National Agreement, Article V. Claims and Payments, 5.11 (d).

G. Review/Revision History

	DATE	ACTION
Date Issued	09/24/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. Program Integrity Requirements Under the Contract, 42 C.F.R. § 438.608 (2025).

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.