2026 NEBRASKA MEDICAID PROVIDER SCREENING AND ENROLLMENT NEWSLETTER

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Go to the Nebraska Medicaid Provider Data Management System (PDMS) Online Portal

KEEPING YOUR PROVIDER AGREEMENT CURRENT

All providers are required to keep their provider agreement current by using the online Nebraska PDMS portal. This includes name, email, phone number, addresses, household members, owners, managing employees, group members, banking information, and other identifying information.

Mental Health Providers need to make sure their Provider Type is always current. Whenever a mental health provider license type changes, the applicable enrollment in Medicaid needs to be end dated immediately and an updated enrollment must be submitted for the new license type effective on the license effective date. Failure to do so in a timely manner may result in denial of a retroactive enrollment/disenrollment request, claim rejections, or payment at the incorrect rate. Retro dates for Mental Health Providers are rarely considered. It is important to keep the information current.

Paper Applications Discontinued

Paper applications are no longer accepted as of June 1st, 2025.

All Nebraska Medicaid Enrollments will be managed by the provider or a representative using the online Nebraska PDMS portal after May 31, 2025. Call customer service at 844-374-5022 if you need assistance navigating the online Provider Data Management (PDMS) portal.

Billing Provider Disenrollments will still be managed using the MLTC-30 paper form. Find all Nebraska Medicaid published forms on their site. More information can be found in the disenrollment section below.

Billing Issues?

All Providers of Managed Care Organizations (MCOs)/Heritage Health

All Providers of Managed Care Organization (MCO) covered services need to make sure their enrollment with Nebraska Medicaid matches their enrollment with each MCO (i.e., practice locations, NPIs, taxonomy codes, etc.). Providers must enroll Medicaid providers (via Maximus) before they can be reimbursed through the MCOs. Failure to do so may impact/delay reimbursement. If there are issues with MCO billing, contact Plan Management at 402-490-5580.

Electronic Visit Verification

The Federal 21st Century Cures Act (2016) required Nebraska Medicaid to implement Electronic Visit Verification (EVV) for applicable Home and Community Based Services (HCBS) (Waiver/PAS) service providers. EVV electronically captures and verifies provider visit information.

If you are providing services and have any questions regarding the EVV project and implementation, please either:

- Email DHHS EVV project team at: DHHS.MedicaidFA-EVV@nebraska.gov
- Reach out to your Resource Development Worker

To learn more about EVV services and receive up-to-date EVV information, please visit or subscribe to the EVV website.

Allow a Few Extra Days for Banking Changes

To assist in fraud mitigation, US Bank performs account validation on new and updated ACH information to ensure it is legitimate and active. Please be aware that this validation process may take additional time, resulting in a delay in payments. Please allow a few extra days AFTER the updated information has been processed and approved.

What's new to the PDMS System

Provider Directory

The Provider Screening and Enrollment system now collects Provider Directory information. Responses to the questions will be included in the public Medicaid provider directory on the DHHS website, as required by the Centers for Medicare and Medicaid Services (CMS). This section is optional, but providers are responsible for ensuring the

accuracy of their information and for updating it regularly in the Provider Data Management System (PDMS).

New MMIS Provider Types

Nebraska Medicaid and Long-Term Care have added new provider types and services. Please stay up to date with changes by reviewing Nebraska Medicaid Provider Bulletins and by utilizing the Nebraska Medicaid Provider Manual.

Here is a list of some of the new Provider Types:

Certified Community Behavioral Health Clinic (CCBHC) (43) and CCBHC Community Resource Specialist (SA), Housing and Employment SMI Specialist (OE), School Based Psychologists (SP), and Rural Emergency Hospitals as a Professional Clinic (PC) (13) with a Rural Emergency Hospitals (92) specialty.

Board Certified Behavioral Analyst (BCBA), and Board Certified Associated Behavioral Analyst (BCaBA) must now be licensed through Nebraska's DHHS Licensing process.

New HCBS (Waiver/PAS) Services

New CDD, DDAD, and FSW services were added in the summer of 2025.

- CDD Waiver 2214 - Youth Continuous Home
- AD Waiver 5011 - LRI Personal Care Individual
- CDD Waiver, DDAD Waiver, and FSW 3593 - LRI Personal Care
- CDD Waiver, DDAD Waiver, and FSW 5663 - Remote Supports Monthly
- CDD Waiver, DDAD Waiver, and FSW 5707 - Health Maintenance Monitoring Installation
- CDD Waiver, DDAD Waiver, and FSW 5936 - Health Maintenance Monitoring Monthly
- CDD Waiver and DDAD Waiver 6104 - Benefits Counseling
- CDD Waiver and DDAD Waiver 6220 - Adult Day Retirement
- AD Waiver 7995 – LRI Personal Care Agency
- CDD Waiver, DDAD Waiver, and FSW 8317 - LRI Personal Care Agency
- CDD Waiver and DDAD Waiver 9281 - Employment Exploration
- CDD Waiver and DDAD Waiver 9307 - RESPITE INDIVIDUAL- AGENCY OUT OF HOME
- CDD Waiver, DDAD Waiver, and FSW 9479 - Remote Supports Installation

CDD Waiver 7286 - THERAPEUTIC RESIDENTIAL HABILITATION was removed.

Please contact your Resource Development Worker with questions.

NPI Requirements for all providers

Nebraska Medicaid is now requiring all Providers, except Non-Emergency Medical Transportation (NEMT) Providers, to obtain and enroll with a National Provider Identifier (NPI). The Department is permitted by 45 CFR Part 162 to require healthcare providers to obtain an NPI for provider screening, enrollment, and billing purposes.

All HCBS (Waiver/PAS) Providers are required to start supplying an NPI as of February 2025. See the applicable Provider Bulletin for more information. View provider bulletins. More information is available on our Provider Ed & Training Resources.

To request an NPI through the National Plan & Provider Enumeration System (NPPES) Registry.

Once the necessary NPI(s) is/are obtained, you must complete the necessary actions to update your current Provider Agreement or start your new Provider Agreement through the Department's Provider Screening and Enrollment vendor (Maximus). The NPI will not automatically be sent from NPPES to NE Medicaid or Maximus. If you have questions, Maximus can be reached at 844-374-5022 or nebraskamedicaidpse@maximus.com however updating the registration must be completed by the provider through the Nebraska Medicaid PDMS Portal.

Each enrollment can only have a single NPI associated with it. Regulatory support for this requested action can be found at 471 NAC 2 005.01 (16) and 471 NAC 3-003 (Billing Requirements).

Ownership Page

You can find more information about ownership disclosures through CMS at CMS.gov with 42 CFR § 455.102. Listing Managing employees is now required through the PDMS System. It is important that you update your ownership and managing employees as changes occur. **Providers that are also enrolled with Medicare need to ensure that both Medicare and Medicaid are kept current. The disclosed owners and managing employees must match.**

Individual Billing Providers must list themselves as owners using their SSN.

Please be sure to always keep all other information on your provider agreement current. Failure to do so may result in adverse action being taken by the Department.

Adult Protective Services, Child Abuse and Neglect Registry Check

Some providers are required to complete Adult and Child Abuse and Neglect Registry Checks (APS/CPS or APS/CAN) at enrollment, yearly as part of their annual screening, and at revalidation. Results must be fewer than 180 days old at the time of screening. If providing services in their home, these checks will also be required for household members aged thirteen and above. See DHHS MLTC Provider Bulletin 18-05 for more information and compliance guidance.

DO NOT DO A SELF-CHECK. Maximus will not receive the results. If a self-check is completed or you have other results from a different organization, Maximus can still use them. **You must send them to Maximus. They must be Nebraska Registry results.**

Here are some basic instructions.

Go to the Central Registry to complete the Identity Verification process and initiate a Central Registry background check for Maximus and Nebraska Medicaid. Note: There is a cost to complete the check as well as a small fee for identity proofing and an online processing fee. The fee is paid to the Central Registry when you request the check. Using the above link will ensure that Maximus and Nebraska Medicaid's Provider Relations team will receive the results.

OR

Complete the paper request form (CFS-5) provided by Maximus (upon request only). This form will include Maximus Health SVCS and Portal ID 80274111 as the Organization ensuring the results are sent to Maximus and Nebraska Medicaid's Provider Relations team.

Note:

- There is a background check fee (check or money order for the amount listed on the CFS-5) that must be sent with the completed CFS-5 form to the Registry's address provided on the back page of the form.
- The form must be notarized and may delay the enrollment process. A notary may charge an additional fee.

Failure to comply with the Central Registry check process will result in closure of your service provider agreement. You have 120 days from the date of the notice to comply. If you have questions about the Central Registry screening process, please contact Children and Family Services at (402) 471-9272 or via email at DHHS.CFSCentralRegistry@nebraska.gov.

More general information about the Registry can be found Abuse and Neglect Central Registry and Expungements.

Required Annual Screenings

Active Individual HCBS (Home and Community Based Service) (Waiver/PAS) and Individual Non-Emergency Medical Transportation (NEMT) providers are required by Nebraska Medicaid to complete Annual Screenings.

All Annual Screenings include:

- Nebraska Data Exchange Network (NDEN)
- Child/Adult Abuse and Neglect Central Registry (more information above and below)
    - New Child/Adult Abuse and Neglect Central Registry checks must be completed
    - Results cannot be more than 6 months old
    - Self-Checks and results requested with other agencies are not available to Maximus. In these situations, it is the Provider's responsibility to ensure Maximus receives a copy of the results
- Sexual Offender Registry (SOR)

Certain services may require the following verifications:

- Driver's License
    - Must be active and have fewer than 3 points.
    - Out of State providers must supply a physical copy of their license upon request. The out of State address on the license must match the Provider's Physical Address unless the provider is a student. Students must also supply a copy of their Student ID.
- CPR and First Aid Training
    - Must be current (expires every 2 years)
- Abuse, Neglect and Exploitation Certification
    - Does not expire but must be available to review in the Provider Agreement
    - Free DHHS Abuse and Neglect Training certification is available
- Traumatic Brain Injury Training
    - Does not expire but must be available to review in the Provider Agreement
- Work/Life/Education Experience
    - 48 months or more of related experience must be listed on the Provider Agreement

Each provider will be notified by email when they are due for Annual Screening. It is important to keep your Provider Agreement information current to ensure notifications are received. Also see the Household members section below.

HCBS (Waiver/PAS) Providers Performing Services in Their Own Household

If your current Provider Agreement indicates that you provide services in your home (as indicated by your Resource Development Worker) you are required to keep your

household members current on your Provider Agreement. All household members should be listed on your Service Provider Agreement. Household members over 13 will be screened.

When household members move out of the household, they need to be removed from your Provider Agreement. New household members need to be added to your Service Provider Agreement immediately.

Limited changes can be made online to your Provider Agreement once you are in Annual Screening. Updating your registration outside of your Annual Screenings will limit your risk of having your Provider Agreement closed.

Non-Emergency Transportation (NEMT) Providers

Individual Net (96) Specialty - MMIS Non-Emergency Medical Transportation - Must be Individual with an SSN. EINs are not permitted. These require Child/Adult Abuse and Neglect Central Registry Checks, Driver's License and Annual Screenings. An NPI is allowed but not required. Type of Practice Category is Individual (62).

Commercial NET (95) Specialty - MMIS Non-Emergency Medical Transportation - The Provider will be screened by Maximus for Accreditation by the Public Service Commission (PSC). The provider is encouraged to keep the PSC office updated and is NOT required to upload the documentation. The certification is required by the PSC prior to enrollment with NE Medicaid. An NPI is allowed but not required. Type of Practice Category is Facility (00).

PSC Exempt (94) - MMIS Non-Emergency Medical-Public Transportation - A PSC Exempt Letter is required to be uploaded to the provider agreement during data entry. The Provider will be screened by Maximus for this Accreditation which includes making sure the EXCEMPT PSC letter is uploaded. Only the Public Service Commission can determine if the transportation provided is exempt.

An NPI is allowed but not required. Type of Practice Category is Facility (00). TRIBAL enrollments still need to have this documentation.

You can also contact the Public Service Commission offices during regular business hours at 402-471-3101.

Contacts for each Heritage Health Managed Care Organizations (MCO) and transportation vendors can be found below.

Revalidations

As mandated by federal regulation 42 CFR 455, Subpart E, Medicaid programs must revalidate all providers every 5 years, regardless of provider type. Some providers (such

as non-citizens of the United States with a time-limited work authorization) may be required to revalidate more often.

Providers in a revalidation period (within 180 days prior to the revalidation due date) will be subject to the following:

Providers who are currently in a revalidation period will receive revalidation notices monthly, starting 180 days prior to the revalidation date, until the revalidation is complete. A total of six-monthly notices will be sent. 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. This can include Adult Protective Services/Child Abuse and Neglect Registry Checks, Fingerprints, and a Site Visit as required. **Submitting early will help prevent delays.**

Updates and adding group members through Manage Members can be completed as part of the 180 day Revalidation process.

If revalidation is not completed by the revalidation date, the Provider Agreement will be closed. The revalidation is not completed when you submit; all required screenings and processes must be completed by Maximus and Nebraska Medicaid. This will take time, submit as early as possible during this 180 day window!

Providers who do not revalidate by their due date must start the enrollment process over and may have a gap in enrollment. Note: This may also impact other agreements including the electronic trading partner agreement for claim submission and the receipt of Medicaid Remittance Advice.

Payment for Nebraska Medicaid payer claims will be impacted for providers who do not revalidate by their revalidation due date. Additionally, prescriber prescription claims will be rejected if the provider is inactive. All prescribers must be active providers for prescriptions, medical supplies, and other services that require an order to be covered for the prescriber's patients.

Shared Living Providers

Shared Living Agency Providers must have an active Group Member Profile. Shared Living Agencies must be actively enrolled for the SHARED LIVING – RESIDENTIAL HABILITATION service (code 1472) before adding Shared Living Group Members. Shared Living Group Members can only be affiliated with three groups MAXIMUM.

Review the Shared Living Provider Instructions on the Provider Education & Training Resources page. Shared Living Providers are required to have an NPI as of February 2025.

Removing your Name from the Nebraska Medicaid Excluded Providers List

If you wish to Re-Enroll as a Nebraska Medicaid Provider, you must first re-apply with Maximus through the Portal. You will be required to complete and pass all required screenings. Thereafter, you will be contacted by Nebraska Medicaid to complete the NMEP removal process. Medicaid Program Integrity makes the final decision regarding NMEP removal. Group Members reapply by being added/confirmed to at least one group.

If you do not wish to reapply but want your name off the Nebraska Exclusion List you must fill out this questionnaire and send it to DHHS.MedicaidProgramIntegrity@nebraska.gov

Please call the Nebraska Inquiry Line at 877-255-3092 with questions.

Fingerprint Criminal Background Checks – FCBC

As mandated by federal regulation 42 CFR 455, Subpart E, effective January 15, 2017, Nebraska Medicaid implemented the collection of fingerprint and criminal background checks for high-risk providers and their owners during enrollment and Revalidation. Therefore, registrations may need additional time to complete this screening process. You should submit Revalidations immediately when notified and respond to all outreach promptly to avoid delays.

Service Provider Agreements may be denied or terminated based on the findings or failure to comply with additional requirements timely. Additional information about these requirements can be found here:

Review Nebraska Medicaid's Fingerprint-Based Criminal Background Check Frequently Asked Questions.

Results must be thirty or fewer days old.

Disenrollment – End Dating a Provider Agreement

To end date a **Billing Provider** Agreement (e.g., disenroll from Nebraska Medicaid), a MTLC-30 disenrollment form must be filled out and submitted to Maximus. Disenrollments should be submitted in a timely manner (within 35 days of the requested end date). Retro disenrollment dates are rarely used. The end date used will likely be defaulted to the disenrollment request submission date or the date it is processed. It is especially important for providers who progress through license types to promptly complete disenrollments and submit enrollment updates for the new license type.

The MLTC-30 disenrollment form can be found on the PDMS portal.

This document can also be requested through Maximus via fax, mail, or email. Once completed, the disenrollment request must be returned to Maximus via fax, mail, or email to complete the disenrollment. Payments will not be made for services rendered after the requested disenrollment date.

Group Members can only be end dated within the Group through the portal. Choosing the current date for disenrollment is standard. If a retro disenrollment date is required, please select a date less than 35 days in the past. If an older retro date is required, you will need to contact Maximus Customer Support at 844-374-5022 for assistance. Please be aware that retro disenrollment dates are rarely approved and can cause a delay in processing. It is especially important for affiliated providers who progress through license types to promptly end date lower level provider types and submit request for the new level. A single provider cannot be active in a group more than once with overlapping effective dates.

Please call customer service at 844-374-5022 if you need assistance.

Retro Enrollment Effective Date Requests

Billing Provider Retro Dates

New Billing Providers (no Medicaid ID number) should request the appropriate Effective Date when completing their application.

Effective Dates requested 180 days or more in the past for MMIS BILLING PROVIDERS are considered a Retro Date Request and must be approved by Nebraska Medicaid.

If the requested Effective Date is over 180 days from the date it is requested the enrollment must include a written explanation as to why this Retro Date is necessary. The written explanation is uploaded to the online registration. The request will automatically be sent to Nebraska Medicaid for approval. If more information is needed, you will be contacted directly. Not responding will result in a denial of your retro effective date.

Please include the following details in your retro enrollment request:

- Include this information with your NEW Registration:
    1. Why are you requesting the retro effective date?
    2. Were emergency services provided to Nebraska Medicaid client(s)?
    3. Detail any circumstances that you believe were beyond the provider's control and provide all supporting documentation
- Are there any pending NE Medicaid claims?

- DO NOT UPLOAD CLAIMS to the system. Email a copy of all pending Nebraska Medicaid claims that support the requested retroactive enrollment effective date directly to DHHS Medicaid Provider Retro Program at DHHS.MedicaidRetroProviderEnrollment@nebraska.gov
- In the Email to DHHS with Claims:
  - List the enrollment Name, NPI, and Physical Address
  - Provide a narrative describing why the provider was providing services to Nebraska Medicaid client(s) prior to being enrolled with Nebraska Medicaid
  - If there are pending claims, please describe when you were alerted that the client(s) had Nebraska Medicaid coverage.
  - Include the answers to numbers 1-3 above

Active Billing Providers (has a Medicaid ID number)

- Retro dates less than 180 days in the past must supply a Retro Date Request in writing (letter or email) to Maximus. Please email your request to Maximus at NebraskaMedicaidPSE@MAXIMUS.com
  - If the Active Billing Provider has a start date and Medicaid ID Number, Maximus can only consider a new retro date if it is within 180 days of the date the new request is made. Other restrictions apply and Retro requests are rarely approved.
  - Maximus will forward requests to Nebraska Medicaid Provider Relations as needed.

- If the requested Effective Date is over 180 days in the past, a request must be submitted to Nebraska Medicaid Provider Relations via email to DHHS.MedicaidRetroProviderEnrollment@nebraska.gov or (402) 471-9018.
  - Please supply the same bulleted information as noted above in your retro enrollment request.
  - Maximus will also forward these requests to Nebraska Medicaid Provider Relations as needed.
  - Retro requests are rarely approved.

MMIS Affiliation Provider Retro Dates (Service Rendering Providers)

Each affiliated provider must first have an approved Group Member Profile and then be specifically affiliated with each service location or group as needed. Each service location/affiliation is considered a unique Medicaid ID with distinct and independent affiliation start dates. The effective date for the Group Member Profile is unrelated to the unique Affiliation effective date at each service location.

New Affiliated Group Members (no Affiliation Medicaid ID number) should request the appropriate Start Date when adding the provider to the Group online. If the requested Start Date is over 180 days from the date it is requested the Group Billing Provider must supply a written request explaining why this Retro Date is necessary. The written explanation is uploaded to the online registration of the Group. This must be done by updating the group, it cannot be completed through the Manage Member Process. The request will automatically be sent to Nebraska Medicaid for approval. Please supply the same bulleted information as noted above with your request.

Please call customer service at 844-374-5022 if you need assistance making this change within the portal. Questions about the retro date approvals over 180 days in the past can be directed to DHHS.MedicaidRetroProviderEnrollment@nebraska.gov or (402) 471-9018.

Active Affiliated Group Members (has an Affiliation Medicaid ID number) must ask for a Retro Start Date within the Group through the online portal. The Group will change the Start Date for the affiliated provider on the Individual Providers page of the Group registration through UPDATE REGISTRATION. This cannot be done through Manage Members. Please call customer service at 844-374-5022 if you need assistance making this change within the portal.

- If the NEW Requested Start Date is less than 180 days from that day's date, the date will be processed by Maximus

- If the NEW Requested Start Date is more than 180 days from that day's date, the request will automatically be sent to Nebraska Medicaid for approval. Please supply the same bulleted information as noted above in your retro enrollment request. Questions can be directed to DHHS.MedicaidRetroProviderEnrollment@nebraska.gov or (402) 471-9018.

HCBS (Waiver/PAS) Providers and Shared Living Provider Retro Dates

HCBS (Waiver/PAS) providers are not granted Retro Dates. The Effective Dates reflect the date all screenings were completed.

Other Contacts

Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5096
Phone Number: 402-471-3121
DHHS Customer Service/Inquiry Lines: 877-255-3092
Medicaid Provider Relations: 402-471-9018
Medicaid Provider Relations Email: DHHS.MedicaidProviderEnrollment@nebraska.gov
DHHS Website Link
Medicaid Provider Relations Retro Date Requests Email:
DHHS.MedicaidRetroProviderEnrollment@nebraska.gov
Provider Bulletin Site:
Email Tax Questions: DHHS.TaxData@nebraska.gov

Managed Care Organizations (MCOs)/ Heritage Health

Visit Heritage Health: Council for Affordable Quality Healthcare (QAQC): (888) 255-2605
Plan Management: 402-490-5580

Visit United Healthcare Community Plan: Provider Services: (877) 842-3210
Transportation: National MedTrans: (833) 583-5683

Visit Nebraska Total Care: Provider Services: (833) 890-0329
Transportation: Medical Transportation Management (MTM): (844) 385-2192

Visit Molina Healthcare: Provider Services: (844) 782-2678
Transportation: Medical Transportation Management (MTM): (888) 889-0421

Dental is now included under health plans.