471-000-507 NEBRASKA MEDICAID PRACTITIONER FEE SCHEDULE FOR DURABLE MEDICAL EQUIPMENT, PROSTHETIC, ORTHOTICS AND MEDICAL SUPPLIES (DMEPOS)

Payment for services as outlined in this fee schedule shall be made as outlined in 471 NAC 7.

The five-digit numeric codes included in the Schedule are obtained from the Physicians' Current Procedural Terminology (CPT). CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. This Schedule includes CPT numeric identifying codes for reporting medical services and procedures.

The Schedule includes only CPT numeric identifying codes for reporting medical services and procedures that were selected by the Nebraska Department of Health and Human Services, State of Nebraska. Any user of CPT outside the Schedule should refer to CPT. This publication contains the complete and most current listings of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.

For DMEPOS items associated with Section 1903(i)(27) of the Social Security Act, amended by Section 5002 of the 21 Century Cures Act, and identified by the Centers of Medicare and Medicaid Services (CMS) as covered by Medicare, Medicaid will pay the lower of the following: (1) The Medicare DMEPOS fee schedule rate for Nebraska geographic, non-rural areas, set as of January 1 of each year, which will be reviewed on a quarterly basis and updated as Medicare updates the fee schedule; (2) the Medicare competitive bidding program rate for the specific item of DME, or (3) the provider's billed charges.

MODIFIERS & BILLING TERMINOLOGY/INFORMATION

Modifier Definitions for DMEPOS

Modifier	Definition
22	Increased Procedural Services
52	Reduced Services
BO	Orally Administered Nutrition
KA	Add-On Option/Accessory for a Wheelchair
KR	Daily Rental for Less than a One Month Period. A Unit is One Day
LL	Conversion of DMEPOS Rental to Purchase. When Using LL Modifier, List the Initial Date of Delivery in Field 19, CMS-1500 Claim Form and Bill Initial Purchase Price.
MS	Six Month Maintenance and Servicing Fee for Reasonable and Necessary Parts and Labor Which are Not Covered Under any Manufacturer or Supplier Warranty. For MS Supplies, Use RB. Clearly State: "Client-Owned Equipment."
NU	New Durable Medical Equipment Purchase
QE	Prescribed Amount of Oxygen is less than 1 Liters per Minute (LPM)
QF	Prescribed Amount of Oxygen Exceeds 4 LPM and Portable Oxygen is Prescribed
QG	Prescribed Amount of Oxygen is Greater than 4 Liters per Minute (LPM)
RA	Replacement of DMEPOS Item Owned by the Client
RB	A Part, in Conjunction with a Repair to a DME Item Owned by the Client. Clearly State: "Client-Owned Equipment."
RR	Rental for a Full One Month Period. A Unit is One Month
UE	Used DMEPOS Purchase. 75% Of Purchase Allowable

A. Medically necessary equipment covered in 471 NAC Chapter 7 do not require prior authorization if repairs (all lines/claims) are billed at a total of $250.00 or less.
B. If the HCPCS code for a repair item does not have a set reimbursement rate (if listed as RNE – rate not established), then the provider must still submit a detailed description and an actual cost invoice with the claim. See Provider Bulletin # 10-17.
C. A Medicaid nutritional supplement "unit" equals 100 calories.
D. For infants/children eligible for Women Infants and Children (WIC), Medicaid covers the difference between the amount of nutritional supplement dispensed by WIC to the client and the amount ordered by the physician.
E. Miscellaneous codes may not be used to claim an item which Medicaid doesn't cover, or to exceed the Medicaid allowable for a type of item with a specific code and allowance.
F. Limits are based on medical necessity.
G. Wheelchair miscellaneous parts may only be billed under K0108.
H. Wheelchair labor is included in the Nursing Facility (NF) and Intermediate Care Facility for the Developmentally Disabled (ICF/DD) per diems as of August 1, 2013.
I. When billing an item where a unit is for one limb (leg, foot, etc.) state whether LT (left) or RT (right). LT or RT goes in the next open modifier field on the claim form. Examples include compression stockings, liners, orthotics and prosthetics.
J. Medicaid does not pay separately for provider's mileage or postage, or supplier's shipping and handling.

Prior Authorization Information

A. All items over $750.00 require a prior authorization.

Purchase items: Prior authorization is required for items greater than $750.00. Rental items: Prior authorization is required when the cost for the entire rental period requested is greater than $750.00 (e.g. $200/month rental charge for a four-month rental period request). Rate not established (RNE): Prior authorization is required for items greater than $750.00. The following codes which generally pay at a rate less than $750.00 require prior authorization: E0265 RR, E0266 RR, E0300 RR, E0303 RR, E0470 RR, E0471 RR, E0667 NU, E0668 NU, E0745 RR, E0747 RR, E0760 RR, E1008 RR, E1161 RR, E1230 RR, E1232 RR, E1233 RR, E1234 RR, E1235 RR, E1236 RR, E1237 RR, E1238 RR, E2510 RR, K0005 RR, K0007 RR, K0011 RR, K0014 RR, K0801 RR, K0802 RR, K0806 RR, K0807 RR, K0808 RR, K0821 K0822 RR, K0823 RR, K0824 RR, K0825 RR, K0826 RR, K0827 RR, K0829 RR, K0837 RR, K0838 RR, K0839 RR, K0841 RR, K0842 RR K0843 RR, K0848 RR, K0849 RR, K0850 RR, K0851 RR, K0856 RR, K0857 RR, K0859 RR, K0861 RR

B. Prior authorizations are good for one year unless otherwise noted for specific equipment.
C. **Prior authorizations are required BEFORE the service or supply will be provided to the client**. The only time prior authorizations are reviewed retroactively is when there is a ward of the state situation or if someone becomes retroactively eligible for Medicaid.

Instructions on How to Use This Document

A. Download the .pdf version to your computer
B. Press Control F and enter the HCPCS Code to determine coverage
C. Use the appropriate modifiers from above.