STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CLINIC SERVICES

Nebraska Medicaid pays for clinic services and outpatient mental health services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Clinic Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

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Payment for Psychiatric Day Treatment Services: Payment rates for psychiatric day treatment services for individuals age 19 and older will be on a unit basis. Rates are set annually for the period July 1 through June 30. Rates are set prospectively for this period and are not adjusted during the rate period. Providers are required to report their costs on an annual basis. Providers desiring to enter the program who have not previously reported their costs or that are newly operated are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers shall submit cost and statistical data on the required form based on the timeframes in 471 NAC 20-003.08. Providers shall compile data based on generally accepted accounting principles and the actual method of accounting based on the provider's fiscal year. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. If the provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will inform the provider via letter that no further payment will be made until a proper cost report is filed. In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care requirements, and discharge planning. The Department does not guarantee that all costs will be reimbursed. The cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

Psychiatric day treatment centers operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

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Payment for Telehealth Services: Payment for telehealth services is included in the cost basis used to set the Medicaid rate.

Health care practitioner services included in a per diem, per monthly, or DRG rate may be provided by telehealth technologies when they otherwise meet the requirements set forth in state regulations, as amended. These services are included in the appropriate cost reports or other accounting data used to calculate the rate.

Payment for Telehealth Transmission Costs: Telehealth transmission costs are allowable costs when they otherwise meet the requirements set forth in state regulations, as amended. These costs are included in the appropriate cost reports or other accounting data used to calculate the rate.

The Department covers transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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Ambulatory Surgical Centers:

Payment of facility fees for services provided in an ambulatory surgical center (both free-standing and hospital-affiliated) is made at the rate established by Medicaid for the appropriate group of procedures.

If one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate. If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure.

Insertion of intraocular lens prosthesis with cataract extration is considered two procedures; payment is made at 150 percent of the applicable group rate. If this procedure is performed bilaterally, payment is made at 150 percent of the group rate for the first procedure (first eye) and 100 percent for the second procedure (second eye).

The ambulatory surgical center may also provide services which are not directly related to the performance of a surgical procedure, such as durable medical equipment, medical supplies, and ambulance services. Payment for these services will be made according to the methods and standards elsewhere in the Title XIX Plan for the appropriate service.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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Pediatric Feeding Disorder Clinic Intensive Day Treatment: Reimbursement for pediatric feeding disorder clinic intensive day treatment for medically necessary services will be a bundled rate based on the sum of the fee schedule amounts for covered services provided by Medicaid enrolled licensed practitioners. This service is reimbursed via a daily rate.

Pediatric Feeding Disorder Clinic Outpatient Treatment: Reimbursement for Pediatric Feeding Disorder Clinic Outpatient Treatment for medically necessary services will be based on the appropriate fee schedule amount for a physician consultation. This service is reimbursed via an encounter rate.

An encounter means a face-to-face visit between a Medicaid-eligible patient and a physician, psychologist, speech therapist, physical therapist, or dietician during which services are rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pediatric feeding disorder services. The agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

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