

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

For EPSDT services provided on or after April 1, 1990, the following applies.

For services reimbursed under the Nebraska Medicaid Practitioner Fee Schedule, NMAP pays for EPSDT services (except for clinical diagnostic laboratory 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 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).

Payment for clinical laboratory services is made at the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare.

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department. Only the administration fee is paid when a physician uses vaccine obtained at no cost from the Nebraska Health and Human Services System.

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

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Medicaid 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.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance abuse treatment services will be paid according to the methodology in Attachment 4.19-A.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rates 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 submitted charge; or (2) the maximum allowable amount.

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

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Other Licensed Practitioners: Licensed Alcohol and Drug Counselor (LADC)

Rehabilitation Services - 42 CFR 440.130(d): Day Treatment/Intensive Outpatient Service by Direct Care Staff; Community Treatment Aide; Professional Resource Family Care; and Therapeutic Group Home

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at <http://www.dhhs.ne.gov/med/provhome.htm> (Division of Medicaid and Long-Term Care website). The above mentioned fee schedule is applicable to all services reimbursed via a fee schedule. The agency's rates were set as of July 1, 2011 and are effective for services provided on or after that date.

The Nebraska Medicaid fee schedule outlined above will be established using the following methodologies:

- If a Medicare fee exists for a defined covered procedure code, then Nebraska will set the Nebraska Medicaid fee schedule for LADC at 95 percent of the licensed Master's level rate paid under Attachment 3.1A, Item 6d for any codes permitted under their scope of practice per Nebraska state law.
- Where Medicare fees do not exist for a covered code, the fee schedule will be set using a market-based pricing methodology as described below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

The market-based pricing methodology will be composed of provider cost modeling for four key components: direct care salary expenses, employee related expenses, program indirect expenses and administrative expenses. The analysis includes national compensation studies for Nebraska to determine the appropriate wage or salary expense for the direct care worker providing each service based on the staffing requirements and roles and responsibilities of the worker, published information related to employee related expenses and other notable cost components and cost data and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development:

- (1) Staffing Assumptions and Staff Wages
- (2) Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- (3) Program-Related Expenses (e.g., supplies)
- (4) Provider Overhead Expenses
- (5) Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.