

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, NMAP pays for anatomical 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 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.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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Approval Date Mar 16 2001

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Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services, including collection of laboratory specimens by venipuncture or catheterization, is paid based on the fee schedule determined by Medicare.

X-Ray Services

For dates of service on or after August 1, 1989, NMAP pays a claim for both the technical and professional components of x-ray 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. Updates are adjusted based on the Medicare fee schedule.

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, 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.

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The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Payment for the professional component only provided to hospital inpatient or outpatient is made according to the Nebraska Medicaid Practitioner Fee Schedule, not to exceed 40 percent of the payment for the total component, as allowed under the fee schedule, for the service provided in a non-hospital setting.

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 submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for 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 audiovisual transmission as set forth in state regulations, as amended.

Transmission costs are not covered when transmission time is negligible. Transmission time is negligible in instances such as, but not limited to, the store and forward transmission of data sent for professional review and interpretation. Transmission time less than 5 minutes for a telehealth service is deemed negligible for Medicaid payment purposes.

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