

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
NOTICE OF PUBLIC HEARING

May 29, 2026  
1:00 P.M. Central Time  
Nebraska State Office Building – Lower Level  
Meadowlark Conference Room  
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 18 of the Nebraska Administrative Code (NAC) – *Physicians' Services*. The proposed changes incorporate the Prenatal Plus Program requirements to the regulation; update definitions; update terminology; modify service requirements; add targeted case management requirements; correct punctuation and typographical errors; add clarification language; remove unnecessary and redundant language; remove duplicate statutory language from the regulation; update section headings; and renumber the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7) and § 68-901 et seq.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax, or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 (fax) or [dhhs.regulations@nebraska.gov](mailto:dhhs.regulations@nebraska.gov), respectively.

A copy of the proposed changes is available online at <http://www.sos.ne.gov>, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

## FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Jeremy Brunssen
Chapter: 18	Date prepared: 11/21/2025
Subject: Physicians' Services	Telephone: (402) 471-5046

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	( <input type="checkbox"/> )	( <input checked="" type="checkbox"/> )	( <input checked="" type="checkbox"/> )
Increased Costs	( <input checked="" type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Costs	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Increased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Indeterminable	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )

Provide an Estimated Cost & Description of Impact:

State agency: Total Impact: SFY25 impact \$1,670,000 (GF: \$704,907 and FF: \$965,093), SFY26 impact \$3,373,400 (GF: \$1,472,826 and FF: \$1,900,574).

Nebraska Medicaid covers Prenatal Plus Program (PPP) services when a Medicaid-eligible pregnant mother has been determined by their prenatal health care provider to be at risk of having negative maternal or infant health outcomes. Prenatal Plus Program (PPP) services include targeted case management (TCM), nutrition counseling, psychosocial counseling, and breastfeeding support. Nebraska Medicaid estimates a recipient population of 4,000 based on the Nebraska Hospital Association (NHA) reported live births from 2023 multiplied by a proxy variable of 0.50 to determine the number of at-risk pregnant Nebraska Medicaid recipients. Nebraska Hospital Association (NHA) data indicates approximately half of the births covered by Nebraska Medicaid had a neonatology code.

Targeted case management (TCM) service: SFY25 impact \$1,200,000 (GF: \$506,520 and FF: \$693,480), SFY26 impact \$2,424,000 (GF: \$1,058,318 and FF: \$1,365,682) – The targeted case management (TCM) cost was calculated by taking the estimated number of Nebraska Medicaid recipients of 4,000 multiplied by the estimated support cost per session of \$100 for six sessions. This rate is in-line with the rate the Department uses for other supports such as counseling and education.

Nutrition counseling service: SFY25 impact \$370,000 (GF: \$156,177 and FF: \$213,823), SFY26 impact \$747,400 (GF: \$326,315 and FF: \$421,085) – The nutrition counseling costs was estimated by taking six sessions of nutrition counseling multiplied by an estimated population of 2,000 Nebraska Medicaid recipients. Nutrition counseling is provided by prenatal clinicians as part of routine prenatal care. Not all Prenatal Plus Program (PPP) participants will utilize nutrition counseling by a licensed medical nutrition therapist (LMNT). Nebraska Medicaid estimates the cost of the initial visit as \$120 and subsequent visits at \$50 per visit. Prenatal Plus Program (PPP) covers up to six sessions of nutrition counseling.

Breastfeeding support service: SFY25 impact \$100,000 (GF: \$42,210 and FF: \$57,790), SFY26 impact \$202,000 (GF: \$88,193 and FF: \$113,807) – The breastfeeding support costs were calculated by taking one session of breastfeeding instruction by a licensed medical nutrition therapist (LMNT) or an international board certified lactation consultant by an estimated population of 2,000 Nebraska Medicaid recipients. Breastfeeding education is provided by prenatal clinicians as part of routine prenatal care, and not all Prenatal Plus Program (PPP) participants will utilize additional breastfeeding support services. Nebraska Medicaid estimates the cost of the visit to be \$100 which is in-line with the rate the Department uses for other supports.

A Prenatal Plus Program (PPP) participant can be referred to a Nebraska Medicaid-enrolled licensed independent practitioner to receive psychosocial counseling an support services. These are covered services and there is no additional costs associated with the regulation.

Given that historical data was the basis for the fiscal estimate, unit cost and utilization trend was applied to the estimates.

Political Subdivision: N/A.

Regulated Public: N/A.

If indeterminable, explain why:

## PROPOSED REGULATION POLICY PRE-REVIEW CHECKLIST

**Agency:** DHHS – Division of Medicaid and Long-Term Care

**Title, Chapter of Regulation:** Title 471 NAC 18

**Subject:** Physicians' Services

**Prepared by:** Bailey Reigle

**Telephone:** 402-429-3080

### **A. Policy Changes and Impacts.**

1. What does the regulation do and whom does it impact? Provide a brief description of the proposed rule or regulation and its impacts on state agencies, political subdivisions, and regulated persons or entities.

Title 471 NAC 18 governs Nebraska Medicaid's coverage of physicians' services. The chapter governs what physician-administered services Nebraska Medicaid covers; what types of health care providers can provide these services; who is eligible for these benefits; and how providers will be reimbursed for providing these services. The proposed regulation changes affect physicians, beneficiaries, and pregnant women.

The proposed changes incorporate services physicians can provide to pregnant women who are a part of the Prenatal Plus Program (PPP).

No other entities are impacted.

2. Describe changes being proposed to current policy and briefly provide rationale.

The proposed regulation changes implement a Prenatal Plus Program (PPP) pursuant to Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-9,105 through 68-9,110, (LB857 (2024)). Pregnant women who have been determined by their prenatal health care provider to be at a high risk of having negative maternal or infant health outcomes will be eligible for Prenatal Plus Program (PPP) services.

The proposed changes:

- Throughout the regulatory chapter
  - Changed the Department to Nebraska Medicaid
  - Changed terminology from individual and client to beneficiary
  - Corrected capitalization, punctuation, and spelling errors
  - Removed names of forms
  - Removed references to other regulation chapters

- Updated section headings
  - Updated acrynoms
  - Removed unnecessary language and unnecessary headings
- Section 001 Scope and Authority
  - Change the to these
  - Add (Neb. Rev. Stat.)
- Section 002 Definitions
  - Updated definitions
  - New definition Non-Patient, removed definition Pregnant Woman's Emergency Medical Condition
  - Renumbered section
- Section 003 Provider Requirements
  - 003.01: Removed unnecessary language and clarified language
  - Updated terminology
  - Renumbered sections and corrected punctuation
- Section 004 Service Requirements
  - Removed unnecessary language and clarified language
  - Updated terminology and removed examples
  - 004.02 (10): Added sleep study language
  - 004.02(E): Updated the prior authorization for bariatric surgery language
  - 004.02(G): Removed section, renumbered remaining sections
  - 004.02(H): Updated language to reflect current prior authorization process
- Section 005 Service-Specific Requirements
  - Correct spelling, updated acrynoms, and updated terminology, and renumbered sections
  - 005.04(B): Added new language regarding bariatric surgery for obesity
  - 005.13(B): Removed section
  - 005.17 and subsections: Added Prenatal Plus Program (PPP) requirements to the regulations: Services, nutrition counseling, psychosocial counseling, support, breastfeeding support, general patient education, and documentation
  - Add targeted case management (TCM) requirements
  - 005.22(A): Updated the allergy injections language, removed duplicative statutory language
  - 005.23: Updated the chemotherapy language
  - 005.27(B)(i): Updated technical component language
  - 005.27(D)(iii)(2): Updated technical component language
  - 005.34(A)-005.34(C)(i): Removed this language
  - 005.36 (B)(i): Removed unnecessary language
- Section 006 Non-Covered Services
  - Removed 006.01 and 006.02 and renumbered the section
  - 006.06(B): Moved this section to end of section 6

- Updated language
- 006.10: New section outlining requests for Nebraska Medicaid Coverage for new or currently non-covered services
- 006.13: Moved from 006.06(B)
- Section 007 Billing for Physician Services
  - Removed Section 007.01
  - 007.02(D)(i): Added a payment exception for Prenatal Plus Program (PPP) services
  - 007.02(J)(i): Removed standby anesthesia language
  - 007.02(L)(iii): Removed section
  - 007.02(S): Removed section
  - Removed unnecessary language, updated acronyms, updated terminology, and renumbered sections
- Section 008 Payment
  - 008.02: Removed
  - 008.02(H)(i): Removed payment for certified registered nurse anesthetists services language
  - Removed unnecessary language, updated terminology, correct typographical errors, and renumbered sections
- Section 009 Prescription drug monitoring program (PDMP)
  - Update terminology, acronyms, and citations

**B. Why is the rule necessary? Explain and provide an identification of authorizing statute(s) or legislative bill(s).**

1. Update of regulation (repeal of obsolete statutes, reflect current policy, editing or technical language changes, etc.)

Update of regulation to implement a Prenatal Plus Program (PPP) pursuant to Neb. Rev. Stat. §§ 68-9,105 through 68-9,110 (LB857 (2024)), and submitted State Plan amendment.

2. Annual changes – cost of living, hunting season schedules, etc.

No.

3. Law was changed – federal \_\_\_ or state \_\_\_X\_\_\_ [Cite authorizing statute(s) or legislative bill(s)]

Neb. Rev. Stat. §§ 68-9,105 through 68-9,110, (LB857 (2024)).

4. Extension of established policy or program, new initiatives or changes in policy (within statutory authority) Yes. This regulation update introduced the Prenatal Plus Program (PPP) which is a new initiative that expands services available to pregnant beneficiaries.

5. Constituent initiated **No.**
6. Financial needs – increases/decreases in fees **No.**
7. Litigation requires changes in rules **No.**
8. Addresses legal or constitutional concerns of Attorney General's office **No.**
9. Implements federal or court mandate **No.**
10. Other (explain)

**C. What happens if these rules are not adopted?**

The regulations will be outdated and not consistent with Nebraska Medicaid's State Plan, and Neb. Rev. Stat. §§ 68-9,105 through 68-9,110, (LB857 (2024)). If not adopted, beneficiaries would not be receiving the high quality comprehensive care and services that the Prenatal Plus Program (PPP) provides which could lead to adverse health outcomes for the mother or baby. These adverse health outcomes would put more of a strain on the providers due to the beneficiaries requiring more medical care.

**D. Policy Checklist.**

1. Is this an update or editorial change reflecting essentially no change in policy? **No.**
2. Does the policy in the proposed regulation reflect legislative intent?  
**Yes.**
3. Is the policy proposed in the regulation a state mandate on local government? **No.** Is it funded? **No.**
4. Is the policy proposed in the regulation a federal mandate on local government? **No.** Is it funded? **No.**

**E. Fiscal Impact. In addition to completing the required Fiscal Impact Statement (a copy must be attached to this document), the agency must address the following:**

1. Will the proposed regulation reduce, increase, or have no change in resources – funds, personnel or FTE? **Increase in aid related costs. There will be an increase due to additional services provided under the Prenatal Plus Program (PPP) such as targeted case management (TCM) and breastfeeding support. Estimated increase in general fund spending of \$704,907 for state fiscal year (SFY) 25 and \$1,472,826 for SFY26.**

2. Have initial contacts been made with citizens or organizations that may be impacted by the proposed regulation? **Yes.** Nebraska Medicaid enrolled providers and interested citizens are aware of these regulation changes as they have been involved with the underlying state statute changes necessitating these changes. Additionally, the Department has engaged with providers and the public as part of the State Plan amendment process to gain federal approval of the program.
3. Does the proposed regulation impact another agency? **No.**
4. Will the proposed regulation reduce, increase, or have no change on reporting requirements of businesses?

Increase. As a condition for reimbursement, the Prenatal Plus Program (PPP) care coordination checklist must be completed and maintained in the pregnant mother's medical records. All activities performed according to the Prenatal Plus Program (PPP) checklist must be documented on the checklist or directly in the beneficiary's medical record. These documents must be made available to the Nebraska Medicaid upon request.

Additionally, Nebraska Medicaid is required to report the number of mothers served, the services offered, and infant health outcomes to the Nebraska legislature annually.

5. What is the agency's best estimate of the additional or reduced spending? If there is none, please note. If receipt of federal funds is contingent upon approval of the proposed regulation, then indicate the amount and nature of the federal funds affected, and enclose laws or correspondence from federal officials substantiating the information.

Estimated increase in general fund spending of \$704,907 for state fiscal year (SFY) 25 and \$1,472,826 for SFY26. Please see Fiscal Impact Statement.

6. Include a description of the impact that the proposed regulation will have on the number of state employees and how the agency intends to address proposed increases or decreases in FTE.

No impact.

**F. Unique problems or issues and recommendations.**

None.

**G. Who is expected to be affected, or to oppose or support the proposed regulation? Explain what initial informal contacts have been made with**

**organizations or citizens who may be affected by the regulation prior to the public hearing.**

It is not anticipated that there will be negative feedback or resistance to these proposed regulations from beneficiaries or Nebraska Medicaid enrolled providers.

Nebraska Medicaid enrolled providers, interested citizens, and beneficiaries are aware of these regulation changes as they have been involved with the underlying state statute changes necessitating these changes. It is not anticipated that there will be negative feedback or resistance to these proposed regulations from beneficiaries or providers.

DHHS will solicit public comment on the proposed regulations before public hearing.

**H. Are these proposed rules a likely candidate for negotiated rulemaking? Explain. Has the process been completed? If so, explain how the issues were addressed.**

No.

**DHHS Division Director's Verification of Review**

I have reviewed these proposals and verify that, at this stage of the regulation's development, these questions have been accurately addressed.



Drew Gonshorowski  
Director  
Division of Medicaid and Long-Term Care  
Department of Health and Human Services

12.12.2025

Date

**TITLE 471**

**NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES**

**CHAPTER 18**

**PHYSICIANS' SERVICES**

**001. SCOPE AND AUTHORITY.** These regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

**002. DEFINITIONS.** The following definitions apply:

**002.01 COMPREHENSIVE INTERDISCIPLINARY TREATMENT.** The collaboration of medicine, psychology, nutrition science, speech-language therapy, occupational therapy (OT), social work, and other appropriate medical and behavioral disciplines in an integrated program.

**002.02 CONSULTING PHYSICIAN.** A physician whose services include history taking, examination of the individual, and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for individuals of other physicians is not considered a consulting physician.

**002.03 EMERGENCY MEDICAL CONDITION.** A medical behavior or condition, the onset of which is sudden, manifesting itself by symptoms of sufficient severity such that the absence of immediate medical attention could result in:

- (A) Placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- (B) Serious impairment to such person's bodily functions; or
- (C) Serious dysfunction of any bodily organ or part.

**002.04 FEEDING AND SWALLOWING CLINIC.** A specialized facility which provides assessment, treatment, ongoing support, and follow-up care for infants and children experiencing feeding difficulties.

**002.05 INDEPENDENT CLINICAL LABORATORY.** A laboratory which is independent both of an attending or consulting physician's office and of a hospital.

**002.06 LABORATORY SERVICES.** Microbiological, serological, chemical, hematological, radio bioassay, cytological, immunohematological, or pathological examinations or procedures performed on materials derived from the individual to provide information for the diagnosis or treatment of a disease, or an assessment of the medical condition of the individual.

**002.07 NON-PATIENT.** A beneficiary who is not directly receiving outpatient services other than diagnostic testing services from the hospital, but the hospital provides all or part of the required clinical diagnostic testing for the beneficiary. The beneficiary is not physically present at the hospital.

002.078 PHYSICIAN CLINIC SERVICES. The professional activity, any drugs and supplies used during that professional encounter, and any other billable service provided in the physician clinic area.

~~002.08~~ ~~PREGNANT WOMAN'S EMERGENCY MEDICAL CONDITION.~~ With respect to a pregnant woman who is having contractions, an emergency medical condition exists when:

- ~~(A) There is inadequate time to safely transfer the woman to another hospital before delivery; or~~
- ~~(B) Transfer to another hospital may pose a threat to the health or safety of the woman or the unborn child.~~

002.09 RADIOLOGY SERVICES. Medically necessary services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic services and associated medical services necessary for the diagnosis and treatment of an individual.

### **003. PROVIDER REQUIREMENTS.**

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, providers of physician services must comply with all applicable provider participation requirements **in this title** codified in Title 471 Nebraska Administrative Code (NAC) 2 and 3. ~~In the event provider participation requirements in Title 471 NAC 2 or 3 conflict with requirements outlined in this 471 NAC 18, the individual provider participation requirements in 471 NAC 18 will govern.~~

#### ~~003.02~~ SPECIFIC PROVIDER REQUIREMENTS.

003.02(A) INDEPENDENT CLINICAL LABORATORIES. An independent clinical laboratory must have a separate provider agreement with the Department **Nebraska Medicaid**. In addition to the provider agreement, independent clinical laboratories must meet the following requirements:

- ~~(i)~~ **(A)** When state or applicable local law requires licensing of independent clinical laboratories, the laboratory must be licensed under the law; and
- ~~(ii)~~ **(B)** The laboratory must meet the health or safety requirements of the United States Secretary of Health and Human Services.

003.023(B) PROVIDERS OF PORTABLE X-RAY SERVICES. To be approved as a Nebraska Medicaid provider, providers of portable x-ray services must be certified by the Centers for Medicare and **& Medicaid Services (CMS) Regional Office**. Each provider must submit to the Department **Nebraska Medicaid** a copy of **the appropriate Nebraska Medicaid approved certification form** Form CMS-1539, Medicare and Medicaid Certification and Transmittal, and remain in compliance with **42 federal regulations (CFR) 486.100 through 486.110**. An out-of-state portable x-ray provider must provide the Department **Nebraska Medicaid** with verification of certification from the Centers for Medicare and **& Medicaid Services (CMS) Regional Office**. ~~The Department approves or denies e~~ Enrollment as a Nebraska Medicaid provider **will be approved or denied** based on the certification information received from the Centers for Medicare and **& Medicaid Services (CMS) Regional Office**.

003.032(BA)(i) APPLICABILITY OF HEALTH AND SAFETY STANDARDS. Providers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services, must comply with all health and safety standards **in Nebraska regulations** NAC Title 180.

003.042(C) PROVIDERS OF NURSE MIDWIFE SERVICES. The **A** nurse midwife is approved for enrollment in **Nebraska** Medicaid under a group provider agreement with the physician with whom they have a practice agreement.

003.052(D) PROVIDERS OF NURSE PRACTITIONER (NP) SERVICES. A nurse practitioner **(NP)** may provide services within the specialty areas in which they hold certification. They must be enrolled in accordance with the **P**provider **A**greement.

003.062(E) FEEDING AND SWALLOWING CLINIC. Along with the completed **appropriate Nebraska Medicaid approved provider agreement** form ~~MC-19: Medical Assistance Provider Agreement~~, the provider must submit a program overview which demonstrates the following components of service are available within the program:

- (A)**i) Interdisciplinary team evaluation which provides information to team members on the individual's **beneficiary's** medical status, and nutrition and diet status, and also addresses feeding and behavioral concerns. In the process of the interdisciplinary team evaluation, the team must review and consider information from other available resources such as attending or referring physician, nursing **facility (NF) home, and school;**
- (B)**ii) Assessment by the **an** occupational therapist **(OT)** of the individual's **beneficiary's** tone and posture to determine seating and positioning for feeding and for the video fluoroscopy procedure;
- (C)**iii) Examination by the **a** speech-**language** pathologist to assess the individual's **beneficiary's** oral structures and clinical swallowing evaluation;
- (D)**iv) A video fluoroscopy swallow study to determine conditions which are most favorable for a safe, efficient swallow and management of feeding problems;
- (E)**v) Assessment of oral motor function and feeding behaviors. Depending on the needs of the individual **beneficiary**, some or all of the team members may be involved in this component. This assessment includes presentation of a variety of amounts and types of foods and liquids to the individual **beneficiary** to provide additional information used to establish therapeutic intervention;
- (F)**vi) Conference by team members to review findings, establish priorities, and coordinate treatment and follow-up recommendations; and
- (G)**vii) Presentation of **a** plan of care to the individual **beneficiary** or family, including instruction, demonstration, and written recommendations for feeding procedures at home and in other environments. ~~This may include school, nursing home, or others involved in the individual's care.~~

#### **004. SERVICE REQUIREMENTS.**

004.01 MEDICAL NECESSITY. ~~The definition of medical necessity from Title 471 NAC 1 is incorporated as if fully rewritten herein. Services and supplies which do not meet the Title 471 NAC 1 definition of medical necessity are not covered.~~ Physicians' services may be provided at the physician's office, the individual's **beneficiary's** home, a hospital, a long-term care facility **(LTC)**, or elsewhere. Additionally, Nebraska Medicaid covers medically necessary physicians' services **are covered** within program guidelines **requirements** which are provided:

- (A)** Within the scope of the practice of medicine or osteopathy as defined by Nebraska state law; and
- (B)** By, or under the personal supervision of, an individual licensed under Nebraska state law to practice medicine or osteopathy.

004.02 PRIOR AUTHORIZATION. For services provided to individuals **beneficiaries** enrolled in a managed care program, physicians must follow **the prior authorization guidelines requirements** of the applicable managed care plan. For all other individuals **beneficiaries**, physicians must request prior authorization from ~~the Department~~ **Nebraska Medicaid** before providing:

- (1) Medical transplants;
- (2) Abortions;
- (3) Cosmetic and reconstructive surgery;
- (4) Bariatric surgery for obesity;
- (5) Out-of-state services, except emergency services provided out-of-state;
- (6) Established procedures of questionable **clinical efficacy current usefulness**;
- (7) Procedures which tend to be redundant when performed in combination with other procedures;
- (8) **New or recently developed** procedures of unproven **clinical efficacy and health outcomes value**;
- (9) Certain drug products; or
- (10) All attended sleep studies; or**
- ~~(11)~~ **(9) Ventricular assist device.**

004.02(A) PRIOR AUTHORIZATION PROCEDURES. Prior to providing the service, a request for prior authorization must be submitted by the physician ~~using the standard electronic Health Care Services Review—Request for Review and Response transaction, Form ASC X12N 278.~~

004.02(A)(i) REQUEST FOR ADDITIONAL EVALUATIONS. ~~The Department may request, and the provider must submit, a~~ **Additional evaluations may be requested, and the provider must submit them,** when ~~the Department~~ **Nebraska Medicaid** determines the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

004.02(A)(ii) NOTIFICATION PROCESS. Upon determination of approval or denial, ~~the Department provides a~~ written notification **is provided**, as applicable, to the physician submitting the request, the caseworker, and the medical review organization.

004.02(A)(iii) VERBAL AUTHORIZATION PROCEDURES. ~~The Department may issue a~~ **A verbal authorization may be issued** when circumstances are of an emergency nature or urgent to the extent a delay would place the individual **beneficiary** at risk of not receiving medical care. When a verbal authorization is granted, the ~~standard electronic Health Care Services Review—Request for Review and Response transaction~~ **physician must submit the appropriate Nebraska Medicaid approved** form must be submitted within 14 calendar days of the verbal authorization.

004.02(A)(iv) BILLING AND PAYMENT REQUIREMENTS. Claims submitted to the ~~Department~~ **Nebraska Medicaid** for services requiring prior authorization will not be paid without written or electronic approval. A copy of the approval documentation issued by ~~the Department~~ **Nebraska Medicaid** is not needed for submission with the claim unless instructed to do so as part of the authorization notification.

004.02(B) PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS. ~~The Department requires a~~ **Authorization is required to** be granted prior to payment for certain drugs or

items. Prior authorization may pertain to either certain drugs prescribed, or certain physician administered drugs. Physicians wishing to prescribe these drugs must obtain prior authorization by submitting the request to either the Nebraska Ppoint of Ssale contractor, or the Nebraska Medicaid, pharmacy unit or its designee. ~~The Department Nebraska Medicaid or the Nebraska point of sale contractor will respond to requests for prior authorization within 24 hours of receipt of the request.~~ In cases of medical emergency, the Nebraska Ppoint of Ssale contractor or the Department Nebraska Medicaid will authorize dispensing a 72 hour supply of a covered outpatient prescribed medication as described in Title 471 NAC 16.

004.02(C) PRODUCTS REQUIRING PRIOR APPROVAL. Identifiable products requiring approval prior to payment are designated as such on the Nebraska Ppoint of Ssale Ssystem or on the Department's Nebraska Medicaid's website. The following prescribed products require prior approval:

- (i) Sunscreen;
- (ii) Certain modified versions, combinations, double-strength entities, or products considered by the Department Nebraska Medicaid to be equivalent to drug products contained on the state maximum allowable cost or federal upper limit listings in this title Title 471 NAC 16;
- (iii) Human growth hormone;
- (iv) Erythropoietin;
- (v) Drugs or supplies intended for convenience use;
- (vi) Drugs used for prevention of infection with respiratory syncytial virus;
- (vii) Certain drugs or classes of drugs used for gastrointestinal disorders, including but not limited to hyperacidity, gastroesophageal reflux disease, ulcers, or dyspepsia;
- (viii) Certain drugs or classes of drugs used for relief of pain, discomfort associated with musculoskeletal conditions, inflammation, or fever;
- (ix) Certain drugs or classes of drugs used for relief of cough or symptoms of the common cold, influenza, or allergic conditions;
- (x) Certain drugs or classes of drugs used for both non-covered services or indications and for covered services or indications;
- (xi) Certain drugs or classes of drugs on the state maximum allowable cost or federal upper limit listings;
- (xii) Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins;
- (xiii) Certain drugs or classes of drugs used for tobacco cessation; and
- (xiv) Certain drugs or classes of drugs determined by the Pharmaceutical and Therapeutics Committee to not be placed onto the Ppreferred Ddrug Llist (PDL).

004.02(D) PRIOR AUTHORIZATION FOR PHYSICIAN ADMINISTERED DRUGS. The following drugs administered in the clinical setting require prior authorization:

- (i) Any drug used for the prevention of respiratory syncytial virus infections;
- (ii) Certain drugs used for the treatment of multiple sclerosis;
- (iii) Enzyme replacement therapy (ERT) or lysosomal storage disorders;
- (iv) Immunoglobulin E (IgE) blocker therapies for asthma;
- (v) Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins; and
- (vi) Drugs not covered under the Nebraska Medicaid Early and Periodic Screening Diagnostic, Diagnosis, and Treatment (EPSDT) program.

004.02(E) PRIOR AUTHORIZATION FOR BARIATRIC SURGERY. Prior authorization requests must include, but are not limited to, documentation of each of **the three following subsections:**

- (i) Medical diagnosis;
- (ii) Body mass index (BMI) 35 or greater with **at least** one of the following co-morbidities:
  - (1) **Type 2 Diabetes mellitus**, including recent laboratory results and current medications;
  - (2) **Medically refractory hypertension**, including current medications, antihypertensive, and blood pressure readings;
  - (3) **Hyperlipidemia, including recent lab results and current medications;**
  - (4) **Cardiovascular disease;**
  - (5) **Coronary artery disease (CAD), congestive heart failure (CHF), dyslipidemia, including recent laboratory results and current medications;**
  - (6) **Obstructive sleep apnea, including sleep study results and treatment;**
  - (7) **Obesity-hypoventilation syndromes;**
  - (8) **Gastroesophageal reflux disease (GERD), including test results and current medications being used to manage the symptoms;**
  - (9) **Osteoarthritis, including information about the individual's beneficiary's ability to ambulate, assistive devices used, and any medications being used to manage symptoms; or**
  - (10) **Idiopathic intracranial hypertension (Pseudotumor cerebri);**—including diagnostic reports, imaging; and
  - (8) ~~Cardiac and pulmonary evaluations and, if existing, cardio-pulmonary co-morbidities and all related consults;~~
- (iii) ~~Dietary consultation, including documentation showing completion of a supervised diet program for six months or more, and a determination the individual is motivated to comply with dietary changes;~~ **Preoperative evaluation within six months of the scheduled surgery that includes:**
  - (1) **Nutritional consultation that includes:**
    - (a) **Diet and physical activity history and patterns of previous weight loss and regain;**
    - (b) **Counseling on steps to modify current problem eating behaviors;**
    - (c) **Counseling on postoperative dietary modifications; and**
    - (d) **Determination of the beneficiary's motivation to comply with dietary modifications to reduce the risk of postoperative complications.**
  - (2) **Psychiatry or psychology consultation that includes:**
    - (a) **Evaluation of the beneficiary to determine readiness for surgery and lifestyle change;**
    - (b) **Assessment for major mental health disorders, psychosocial functioning, alcohol and substance use disorder, and maladaptive eating behaviors; and**
    - (c) **Adequate treatment as needed, to maximize successful postoperative outcomes.**
  - (3) **Medical clearance that includes:**
    - (a) **Evaluation of cardiac and pulmonary risk;**
    - (b) **Nutritional, hormonal, and other lab parameters as indicated;**
    - (c) **No history of tobacco use, or tobacco cessation has been attempted prior to surgery; and**
    - (d) **Beneficiary's understanding of surgical risk, postoperative compliance, and follow-up.**

- (iv) ~~Psychiatry or Psychology consultation which includes:
 
  - (1) Evaluation to determine readiness for surgery and lifestyle change; and
  - (2) No behavior health disorder by history and physical exam;
    - (a) Exam includes no severe psychosis or personality disorder; and
    - (b) Mood or anxiety disorder excluded treatment. If treated, include treatment medications and modalities;~~
- (v) ~~Drug or alcohol screen;
 
  - (1) No drugs or alcohol by history, or alcohol and drug free for a period of at least one year; and
  - (2) No history of smoking, or smoking cessation has been attempted; and~~
- (vi) ~~individual's understanding of surgical risk, post procedure compliance and follow-up.~~

004.02(F) PRIOR AUTHORIZATION FOR TRANSPLANT SERVICES. Nebraska Medicaid requires ~~p~~Prior authorization **is required** of all transplant services. Physicians must request and receive prior authorization before performing any transplant service or related donor service. The request for authorization must include, at a minimum:

- (i) The individual's **beneficiary's** name, **Nebraska** Medicaid identification number, and date of birth;
- (ii) Diagnosis, pertinent past medical history and treatment, prognosis with and without the transplant, and the procedures for which the authorization is requested;
- (iii) Name of the hospital, city, and state where the services will be performed, including the National Provider Identifier (NPI) of the provider;
  - (1) All providers must be enrolled with Nebraska Medicaid before services are performed. ~~Out-of-state services are covered in accordance with Title 471 NAC 4;~~
- (iv) Name of the physician who will perform the surgery if other than the physician requesting authorization; **and**
- (v) ~~In addition to the above information, a~~ **A** physician specializing in the specific transplantation must also supply the following:
  - (1) The screening criteria used in determining an individual **if the beneficiary** is an appropriate candidate for a liver, heart, allogenic, intestinal, or multi-visceral transplant;
  - (2) The results of the screening for the **beneficiary** individual; and
  - (3) A written statement by the physician:
    - (a) Recommending the transplant;
    - (b) Certifying and explaining why the transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the **beneficiary's** individual's life in a meaningful, qualitative way and at a reasonable level of functioning; ~~and~~
    - (c) Including a psycho-social evaluation for solid organ transplants; and
    - (~~vid~~) **For** heart, lung, liver, stem cell, bone marrow, allogeneic, or intestinal or multi-visceral transplants, a second physician specializing in the specified transplant must also supply the above required information.

~~004.02(G) PRIOR AUTHORIZATION FOR NEW OR UNUSUAL SURGICAL PROCEDURES.~~ A provider must request and receive prior authorization from the Department for all new or unusual surgical procedures. The provider must submit a copy of the notification of authorization only when instructed to do so in the text of the authorization.

004.02(HG) PRIOR AUTHORIZATION FOR COSMETIC AND RECONSTRUCTIVE SURGERY. In addition to the prior authorization requirements included in this chapter, the surgeon who will be performing the cosmetic or reconstructive surgery must submit a request to the Department **Nebraska Medicaid**. This request must include the following:

- (i) An overview of the medical condition and medical history of any conditions caused or aggravated by the condition;
- (ii) Photographs of the involved area when appropriate to the request;
- (iii) A description of the procedure being requested, including any plan to perform the procedure when it requires a staged process; and
- (iv) When appropriate, additional information regarding the medical history may be submitted by the **beneficiary's** individual's primary care physician.

004.02(H) PRIOR AUTHORIZATION OF RADIOLOGY PROCEDURES. ~~Nebraska Medicaid does not require prior authorization for individuals enrolled in fee-for-service needing radiology procedures. For members covered by a managed care organization, refer to the plan for prior authorization procedures.~~ All non-emergency outpatient computerized tomography (CT) scans, magnetic resonance angiogram (MRA) scans, magnetic resonance imaging (MRI) scans, magnetic resonance spectroscopy (MRS) scans, nuclear medicine cardiology scans, positron emission tomography (PET) scans, and single photon emission computed tomography (SPECT) will require prior authorization. These prior authorization requirements apply for all Nebraska Medicaid beneficiaries enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency department.

004.02(JI) PRIOR AUTHORIZATION FOR COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER. Prior authorization is required for all services before the services are provided. The requesting physician must submit a request to the Department **Nebraska Medicaid** including the following information or explanation as appropriate to the case:

- (i) A referral from the primary care physician which includes current appropriate medical evaluations or treatment plans;
- (ii) Medical records for the last year which include height and weight measurements; and
- (iii) Any records from feeding and swallowing clinic evaluations and other therapeutic interventions which have occurred.

004.03 DEFINITIONS AND TERMS OF COMMONALITY. The Current Procedural Terminology (CPT) contains terms and phrases common to the practice of medicine. Claims for physicians' services must be coded according to the definitions in the Current Procedural Terminology (CPT). At the request of the Department **Nebraska Medicaid**, the provider must submit copies of individual's **the beneficiary's** medical records to document the level of care provided. If the requested documentation is not provided or is insufficient in contents, payment may be withheld or recouped. ~~The Department recognizes the definitions and reporting requirements of the Current Procedural Terminology (CPT), but coverage of Nebraska Medicaid services is based on the regulations in NAC Title 471.~~

## **005. SERVICE-SPECIFIC REQUIREMENTS.**

005.01 FACILITY-BASED PHYSICIAN CLINICS. Physician clinic services provided in a hospital location or a facility under the hospital's licensure are considered to be a physician service, not an outpatient hospital service.

- (A) ~~The Department does not recognize f~~Facility or hospital-based non-emergency physician clinics **are not recognized** for billing, reimbursement, or cost reporting purposes except for itinerant physicians as defined in **this chapter 471-NAC-18**.
- (B) Services and supplies incident to a physician's professional service provided during a specific encounter are covered and reimbursed as physician clinic services if the service or supply is:
  - (i) Of the type commonly furnished in a physician's office;
  - (ii) Furnished as an incidental, although integral, part of the physician professional service; and
  - (iii) Furnished under the direct personal supervision of the physician.

005.02 HOSPITAL ADMISSION DIAGNOSTIC PROCEDURES. In addition to the previously defined medical necessity requirements, ~~the Department will consider~~ the following **will be considered** to determine whether a diagnostic procedure performed as part of the admitting procedure to a hospital is reasonable and medically necessary:

- (A) The test is specifically ordered by the ~~admitting~~ **attending** physician, or a hospital staff physician responsible for the ~~individual~~ **beneficiary** when there is no ~~admitting attending~~ physician;
- (B) The test is medically necessary for the diagnosis or treatment of the ~~individual's~~ **beneficiary's** condition; and
- (C) The test does not unnecessarily duplicate:
  - (i) The same test performed on an outpatient basis before admission; or
  - (ii) The same test performed in connection with a separate, but recent, hospital admission.

005.03 MINOR SURGICAL PROCEDURES. Reimbursement for excision of lesions of the skin or subcutaneous tissues include all services and supplies necessary to provide the service. ~~The Department does not make a~~Additional reimbursement **is not made** for suture removal to the physician who performed the initial services, or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the ~~physician who provided the initial service,~~ **the Department may approve separate payment may be approved** for the suture removal.

005.04 TREATMENT FOR OBESITY. ~~The Department will not make~~ **There will be no payment made** for services provided when the sole diagnosis is obesity. While obesity is not itself considered an illness, there are conditions which can be caused by or aggravated by obesity. Treatment for obesity may be covered when the services are an integral and necessary part of a course of treatment or treatment for covered co-morbidities.

005.04(A) INTESTINAL BYPASS SURGERY. ~~Nebraska Medicaid does not cover~~ **Intestinal bypass surgery for treatment of obesity is not covered.**

005.04(B) BARIATRIC SURGERY FOR OBESITY. **Bariatric surgery for beneficiaries with obesity may be covered when the surgery is medically appropriate for the beneficiary, and is performed to correct an illness which either causes obesity or was aggravated by obesity. Proof of accreditation must be submitted with each prior approval request. This procedure must be performed at a facility that is one of the following:**

- (1) Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP); or
- (2) A children's hospital that has a comprehensive multidisciplinary bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and psychosocial needs of the client and family.

~~Bariatric Surgery Center of Excellence. Bariatric surgery for individuals with severe obesity may be covered when the surgery is medically appropriate for the individual and is performed to correct an illness which either causes the obesity or was aggravated by obesity.~~

005.05 COSMETIC AND RECONSTRUCTIVE SURGERY. ~~Nebraska Medicaid covers~~ Cosmetic and reconstructive surgical procedures and medical services, **are covered** when medically necessary, for the purpose of correcting the following conditions:

- (1) Limitations in movement of a body part caused by trauma or congenital conditions;
- (2) Disfiguring or painful scars in areas which are visible;
- (3) Congenital birth anomalies **that result in functional impairment or are severely disfiguring;**
- (4) Post-mastectomy breast reconstruction; and
- (5) Other procedures determined to be restorative or necessary to correct a medical condition.

005.05(A) EXCEPTIONS. To determine the medical necessity of the condition, ~~the Department requires~~ prior authorization **is required** for cosmetic and reconstructive surgical procedures except for the following conditions:

- (i) Cleft lip and cleft palate;
- (ii) Post-mastectomy breast reconstruction;
- (iii) Congenital hemangiomas of the face; and
- (iv) Nevus removals.

005.06 STERILIZATIONS.

005.06(A) COVERAGE RESTRICTIONS. ~~Nebraska Medicaid does not cover~~ Sterilization of **beneficiaries** individuals **is not covered** when the beneficiary is:

- (i) Under the age of 21 on the date the ~~individual~~ **beneficiary** signs **the appropriate Nebraska Medicaid approved consent form Form MMS-100: Sterilization Consent Form;** or
- (ii) ~~Who are mentally incompetent or institutionalized~~ **Legally incapable of consenting to sterilization.**

005.06(B) COVERAGE CONDITIONS. ~~Nebraska Medicaid covers~~ Sterilizations **are** only **covered** when:

- (i) The sterilization is performed because the ~~individual~~ **beneficiary** receiving the service made a voluntary request for services;
- (ii) The ~~individual~~ **beneficiary** is advised at the outset and before the request or receipt of their consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized;
- (iii) ~~Individuals~~ **Beneficiaries** whose primary language is other than English are provided with the required elements for informed consent in their primary language; and

- (iv) Suitable arrangements are made to communicate the required elements of informed consent to an individual beneficiary who is blind, deaf, hard of hearing, or is otherwise disabled has a communication disability.

005.06(C) PROCEDURE FOR OBTAINING SERVICES. Non-therapeutic sterilizations are covered by Nebraska Medicaid only when:

- (i) Legally effective informed consent is obtained on the appropriate Nebraska Medicaid approved consent form Form MMS-100: Sterilization Consent Form from the individual beneficiary on whom the sterilization is to be performed. The surgeon must submit a completed form to the Department Nebraska Medicaid before payment of claims can be considered; and
- (ii) The sterilization is performed at least 30 days following the date informed consent was given. To calculate this time period, day 4 one is the first day following the date on which the form is signed by the individual beneficiary. Day 31 in this period is the first day on which the procedure may be covered. The consent is effective for 180 days from the individual's beneficiary's signature.

005.06(D) EXCEPTION. An individual beneficiary may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the individual beneficiary signed the informed consent for the sterilization. For a premature delivery, the individual beneficiary must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery. The expected delivery date must be entered on the appropriate Nebraska Medicaid approved consent form Form MMS-100: Sterilization Consent Form.

005.06(E) INFORMED CONSENT. Informed consent means the voluntary, knowing assent of the individual beneficiary who is to be sterilized after they have been given the following information and completed the appropriate Nebraska Medicaid consent form Form MMS-100: Sterilization Consent Form:

- (i) A clear explanation of the procedures to be followed;
- (ii) A full description of the discomforts and risks which may follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- (iii) A description of the benefits to be expected;
- (iv) Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;
- (v) An offer to answer any questions concerning the procedures;
- (vi) An instruction that the individual beneficiary is free to withhold or withdraw consent to the sterilization at any time before the sterilization without prejudicing future care and without loss of other project or program benefits to which the individual beneficiary might otherwise be entitled;
- (vii) Advice that the sterilization will not be performed for at least 30 days, except under the circumstances previously specified; and
- (viii) The individual beneficiary to be sterilized must be permitted to have a witness of his or her choice present when informed consent was obtained.

005.06(F) STERILIZATION CONSENT FORMS. The surgeon will submit a completed Nebraska Medicaid approved consent form Form MMS-100: Sterilization Consent Form to the Department Nebraska Medicaid before payment of claims can be considered. The Sterilization Consent Form must be signed and dated by the individual beneficiary to be

sterilized, the person obtaining consent, the physician who will perform the procedure, and the interpreter if one was provided.

005.07 HYSTERECTOMIES. ~~Nebraska Medicaid covers a medically necessary hysterectomy if the following conditions have been met, and a completed form is submitted to the Department of Health and Human Services, Nebraska Medicaid by the surgeon before claims for the hysterectomy can be considered for payment:~~

- (1) The ~~individual~~ provider who secured authorization to perform the hysterectomy has informed the ~~individual~~ woman and her representative, if any, orally and in writing, that the hysterectomy will make the ~~individual~~ woman permanently incapable of reproducing; and
- (2) The ~~individual~~ woman or her representative, if any, has signed the appropriate Nebraska Medicaid approved consent form Form MMS-101: Informed Consent for Hysterectomy, acknowledging receipt of the above information.

005.07(A) EXCEPTION. Informed consent is not required in the following situations. ~~and a copy of the surgeon's certification of the following exceptions must be submitted to the Department of Health and Human Services, Nebraska Medicaid prior to consideration of payment for claims associated with the hysterectomy:~~

- (i) The ~~individual~~ woman was sterile before the hysterectomy, and the physician performing the hysterectomy certifies in writing that the ~~individual~~ woman was sterile before the hysterectomy and states the cause of the sterility;
- (ii) ~~Nebraska Medicaid considers post-menopausal women~~ ~~are considered~~ to be sterile. All claims related to the procedure must indicate the ~~individual~~ woman is post-menopausal; or
- (iii) The ~~individual~~ woman requires a hysterectomy due to a life-threatening emergency situation and the physician determines informed consent is not possible. The physician performing the hysterectomy must certify, in writing, that the hysterectomy was performed under a life-threatening emergency situation in which informed consent was not possible. The physician must also include a certification of the emergency.

005.07(B) NON-COVERED HYSTERECTOMIES. ~~Nebraska Medicaid does not cover a hysterectomy if it was performed solely to make the woman sterile or, if there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.~~

005.08 INFERTILITY. ~~Nebraska Medicaid limits coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical condition. Reimbursement or coverage is not available when the sole purpose of the service is achieving a pregnancy.~~

005.09 ALCOHOL AND CHEMICAL DETOXIFICATION. ~~Nebraska Medicaid limits alcohol and chemical detoxification to medically necessary treatment, subject to the Department's Nebraska Medicaid utilization review.~~

005.10 OSTEOGENIC STIMULATION. Electrical stimulation to augment bone repair, also known as osteogenic stimulation, can be performed either invasively or noninvasively.

005.10(A) INVASIVE OSTEOGENIC STIMULATION. ~~Nebraska Medicaid covers the use of the invasive device only for non-union of long bone fractures. Nebraska~~

~~Medicaid considers a~~ Non-union is **considered** to exist only after six months or more have elapsed without the fracture healing.

005.10(B) NON-INVASIVE OSTEOGENIC STIMULATION. ~~Nebraska Medicaid covers~~ **The use of the non-invasive device is covered** only for non-union of long bone fractures, failed fusion, or congenital psueudoarthroses.

005.11 BIOFEEDBACK THERAPY. ~~Nebraska Medicaid covers b~~ **Biofeedback therapy is covered** only when it is reasonable and necessary for the ~~individual~~ **beneficiary** for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments have not been successful. This therapy is not covered for treatment of ordinary muscle tension states, for psychosomatic conditions, or for psychiatric conditions.

005.12 SLEEP DISORDER CLINICS. Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. ~~Nebraska Medicaid covers d~~ **Diagnostic and therapeutic services of a sleep disorder clinic are covered** under the following conditions.

005.12(A) DIAGNOSTIC SERVICES. Diagnostic testing which is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered. ~~Individuals~~ **Beneficiaries** who undergo diagnostic testing are not considered inpatients; however, if required as part of the diagnostic testing, the overnight stay is considered an integral part of these tests. All reasonable and necessary diagnostic tests given for narcolepsy and sleep apnea are covered when the following criteria are met:

- (i) The clinic ~~must be~~ **is** affiliated with a hospital;
- (ii) The ~~individual~~ **beneficiary** ~~must be~~ **is** referred to the sleep disorder clinic by a physician. The clinic must maintain a record of the attending physician's orders **with the physician's signature**; and
- (iii) The need for diagnostic testing ~~must be~~ **is** confirmed by medical evidence, such as physician examinations and laboratory tests.

005.12(B) THERAPEUTIC SERVICES. ~~Nebraska Medicaid may cover t~~ **Therapeutic services may be covered** provided they are standard and accepted services and are reasonable and medically necessary for the ~~beneficiary~~ **individual**. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services may be provided for:

- (i) Insomnia which is not associated with psychiatric disorders;
- (ii) Nocturnal myoclonus, also known as muscle jerks;
- (iii) Sleep apnea;
- (iv) Drug dependency;
- (v) Shift work and schedule disturbances;
- (vi) Restless leg syndrome;
- (vii) Hypersomnia, also known as excessive daytime sleepiness;
- (viii) Somnambulism;
- (ix) Night terrors or dream anxiety attacks;
- (x) Enuresis; and
- (xi) Bruxism.

005.13 SURGERY. ~~Nebraska Medicaid covers s~~ **Surgical procedures are covered**, including 14 days of post-operative care. When multiple procedures are performed at the same time, the primary procedure and any secondary procedures are covered and reimbursed in

accordance with this chapter. Incidental procedures through the same incision are not considered separate secondary procedures for reimbursement.

005.13(A) ASSISTANT SURGEON. ~~Nebraska Medicaid covers t~~The services of an assistant surgeon **are covered** when reasonable and medically necessary.

005.13(B) NEW OR UNUSUAL SURGICAL PROCEDURES. ~~Nebraska Medicaid may cover new or unusual surgical procedures. In all cases, the Department will determine the necessity or usefulness of the procedure pursuant to a prior authorization request.~~

005.13(C) SECOND SURGICAL OPINION. ~~Nebraska Medicaid provides coverage for individuals~~ Beneficiaries who desire a second physician's opinion concerning proposed surgery **have coverage to receive a second physician's opinion.**

005.13(D) SERVICES PERFORMED IN AN AMBULATORY SURGICAL CENTER (ASC). In addition to the federally identified ambulatory surgical center (ASC) services, ~~Nebraska Medicaid covers the certain state-defined services provided in an ambulatory surgical center (ASC) are covered.~~ Payment for facility services provided in connection with the state-defined procedures will not exceed payment for the corresponding group of Medicare-covered ambulatory surgical center procedures. Federally identified ambulatory surgical center services are defined in 471 NAC 26.

005.14 HOSPITAL VISITS. ~~Nebraska Medicaid covers o~~Only one visit per day by the same physician, or physicians of the same specialty from the same group practice **is covered**, unless the primary physician states on **the appropriate Nebraska Medicaid approved claim form** Form CMS-1500: Health Insurance Claim Form, or electronically, more than one visit was necessary because of serious illness or change in condition, and approval is given by **Nebraska Medicaid** the Department.

005.14(A) SURVEILLANCE AND UTILIZATION REVIEW CRITERIA. ~~The Department may contract with a~~ A medical review organization **may be utilized** to review inpatient hospital services. The physician must comply with all medical review requirements. For hospitalizations not subject to medical review, ~~the Department's~~ **Nebraska Medicaid's** in-house utilization review will prevail. If a hospitalization is denied or reduced based on utilization review, the physician's claim may also be denied or reduced accordingly.

005.15 EMERGENCY ROOM SERVICES. At least one of the following conditions must be met before ~~the Department approves~~ payment **is approved** for use of an emergency room:

- (1) The individual **beneficiary** is evaluated or treated for an emergency medical condition. The facility must review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly;
- (2) If the individual's **beneficiary's** evaluation or treatment in the emergency room results in an approved inpatient hospital admission, the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem; or
- (3) The individual **beneficiary** is referred by his or her physician for treatment in an emergency room.

005.15(A) NON-EMERGENT SERVICES. When the facility or ~~the Department~~ **Nebraska Medicaid** determines services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of what would otherwise

be allowed. When these conditions are met, the physician's fee will be disallowed to the rate of a comparable office service. ~~All other Nebraska Medicaid allowable charges incurred in this type of visit will be paid according to Title 471 NAC 10.~~

005.16 PRENATAL, DELIVERY, AND POSTPARTUM CARE. ~~Nebraska Medicaid covers~~ Physicians' services related to pregnancy **are covered**. Routine prenatal care, delivery, six weeks' postpartum care, and routine urinalysis are reimbursed as a package service. The physician may claim, as independent procedures, those laboratory and medical services which are not related to the pregnancy, or which are not included as part of the **global fee** package service. Postpartum services are covered through the applicable postpartum period ~~defined in Title 477 NAC 1,~~ for **women beneficiaries** who were eligible for, applied for, and received medical assistance on the day the pregnancy ends. After the infant is delivered, the infant is treated as a separate patient for reimbursement purposes.

005.16(A) CERTIFIED NURSE MIDWIFE (CNM) SERVICES. ~~Nebraska Medicaid covers~~ **Certified** nurse midwife **(CNM)** services which are medically necessary and provided in accordance with the practice as defined by law **are covered**. ~~Nebraska Medicaid does not cover~~ Routine office visits to a physician **are not covered** when a **certified** nurse midwife **(CNM)** is providing complete obstetrical care, unless documentation of medical necessity for the physician's office visit is submitted. ~~Nebraska Medicaid covers~~ **Prenatal** ~~pre-natal~~ care, delivery, and ~~post-partum~~ **postpartum** care **is covered** as a package **global** service. Auxiliary services, such as **prenatal** ~~pre-natal~~ classes and home visits, are not paid separately.

005.17 PRENATAL PLUS PROGRAM (PPP). **Prenatal Plus Program (PPP) services are covered when a Nebraska Medicaid-eligible pregnant mother has been determined by their prenatal health care provider to be at risk of having a negative maternal or infant health outcome.**

005.17(A) NUTRITION COUNSELING. **Nutrition counseling is provided by the prenatal clinician as part of routine prenatal care and is not reimbursed separately. If the beneficiary is referred to a licensed medical nutrition therapist (LMNT), the Prenatal Plus Program (PPP) covers up to six sessions of nutrition counseling. These sessions can be provided in-person or via audiovisual telehealth.**

005.17(B) PSYCHOSOCIAL COUNSELING AND SUPPORT. **If the beneficiary has mental health or substance use disorder needs, the beneficiary can be referred to a Nebraska Medicaid enrolled licensed independent practitioner to receive psychosocial counseling and support services.**

005.17(C) BREASTFEEDING SUPPORT. **Breastfeeding education is provided by the prenatal clinician as part of routine prenatal care and is not reimbursed separately. If the beneficiary is referred for a breastfeeding instruction session, it must be provided by a licensed medical nutrition therapist (LMNT) or an international board-certified lactation consultant (IBCLC). The session can be provided in-person or via audiovisual telehealth and in an individual or group setting. Beneficiaries are limited to one session per pregnancy.**

005.17(D) GENERAL PATIENT EDUCATION AND HEALTH PROMOTION. **The prenatal clinician provides beneficiary education as part of routine care and is not reimbursed**

separately. The beneficiary can be referred to an appropriate resource to receive the education.

005.17(E) TARGETED CASE MANAGEMENT (TCM). Targeted case management (TCM) services are provided to assist beneficiaries in gaining access to needed services. This includes a comprehensive assessment, periodic reassessment of the beneficiary's needs, development and revision of a specific care plan that specifies goals and actions, referral to help the beneficiary obtain needed services, and monitoring and follow-up activities to ensure the care plan is implemented. Targeted case management (TCM) can be provided in-person, via audiovisual telehealth, or by telephone. A minimum of one targeted case management (TCM) interaction per month is required for reimbursement.

005.17(F) PRENATAL PLUS PROGRAM (PPP) DOCUMENTATION. All documentation for the Prenatal Plus Program (PPP) must be completed and maintained in the beneficiary's medical records. All activities performed must be documented on the appropriate Nebraska Medicaid approved checklist form or directly in the beneficiary's medical record. The documents must be made available to Nebraska Medicaid upon request.

~~005.187~~ ANTIGENS THERAPY. ~~Nebraska Medicaid may make p~~ Payment for a reasonable supply of antigens which have been prepared for and administered to a particular individual beneficiary even though the antigens have not been administered to the individual beneficiary by the same physician who prepared them may be made if:

- (A) The antigens are prepared by a physician who is a doctor of medicine or osteopathy; and
- (B) The physician who prepared the antigens has examined the individual beneficiary and determined a plan of treatment and a dosage regimen.

~~005.198~~ DIALYSIS. Nebraska Medicaid follows Medicare's guidelines requirements for coverage of dialysis are followed.

~~005.2049~~ FAMILY PLANNING SERVICES. ~~Nebraska Medicaid covers f~~ Family planning services, including consultation and procedures, provided upon the request of the beneficiary individual are covered. The individual beneficiary must be allowed to exercise freedom of choice in choosing a method of family planning. Family planning services performed in family planning clinics must be prescribed by a physician, and must be and furnished, directed, or supervised by a physician or registered nurse (RN). Family planning services must:

- (A) Be provided without regard to age, sex, or marital status. There can be no discrimination in the provision of services and information; and
- (B) ~~The scope of~~ Include available services and information ~~must include~~ relating to medical, social, and educational services and information, including initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

~~005.210~~ FRACTURE CARE. Coverage of initial fracture care includes the application and removal of the first cast or traction device.

~~005.21~~ DRUGS.

005.224(A) COVERED DRUGS. Nebraska Medicaid covers ~~Outpatient~~ outpatient prescription drugs ~~are covered~~ in accordance with ~~federal law~~ the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) Public Law 101-508 including legend drugs, compounded prescriptions, and over the counter (OTC) drugs indicated as covered on the Nebraska ~~Point of Sale~~ ~~System~~ or listed on the Department's ~~Nebraska Medicaid's~~ website.

005.224(A)(i) PREFERRED DRUG LIST (PDL). Nebraska Medicaid ~~Prescribed drugs~~ which are found to be therapeutically equivalent to or superior to other drugs within a therapeutic class and whose net cost is equal to or less than other drugs within a therapeutic class after consideration of applicable rebates or discounts negotiated by the ~~Department or its designated contractor~~ will be included on the preferred drug list (PDL) ~~prescribed drugs which are found to be therapeutically equivalent to or superior to other drugs within a therapeutic class, and the net cost of the drugs are equal to or less than other drugs within a therapeutic class after consideration of applicable rebates or discounts negotiated by the Department or its designated contractor.~~ Medications designated as non-preferred on the preferred drug list (PDL) will be subject to prior authorization. The ~~Pharmaceutical and Therapeutics Committee will develop criteria for use of medications with non-preferred status.~~ The Department will maintain an updated preferred drug list in electronic format and will make the list available to the public on the Department's internet website.

005.22(B)1(A)(ii) COMPOUNDED PRESCRIPTIONS. Any mixture of drugs which results in a commercially available over the counter (OTC) preparation is not considered a compounded prescription.

005.22(C)1(A)(iii) OVER THE COUNTER (OTC) DRUGS. Nebraska Medicaid covers ~~Only~~ over the counter (OTC) drugs indicated as covered on the Nebraska ~~Point of Sale~~ ~~System~~ or listed on the Department's ~~Nebraska Medicaid's~~ website ~~are covered~~. Over the counter (OTC) drugs must be prescribed by a licensed practitioner.

005.22(D)1(B) BRAND NECESSARY CERTIFICATION OF DRUGS. The Federal Upper Limit (FUL) or State Maximum Allowable Cost (SMAC) limitations will not apply in any case where the prescribing physician certifies a specific brand is medically necessary. In these cases, the usual and customary charge, or National Average Drug Acquisition Cost (NADAC) will be the maximum allowable cost. The prescriber must certify on ~~the appropriate Nebraska Medicaid approved physician's certification form~~ Form MC-6: ~~Physician's Certification Form~~ that a brand name is medically necessary.

005.22(E)1(G) INJECTIONS. In addition to the limitations in 471 NAC 16, ~~injections~~ injections administered by the physician in the clinical setting are not reimbursable through the outpatient drug program. Medications used in this manner are considered medical services and are to be purchased, used, and billed to the Department ~~Nebraska Medicaid~~ by the physician or clinic.

005.232 PRACTITIONER-ADMINISTERED MEDICATIONS. Practitioner administered injectable medications will be reimbursed at average sales prices (ASP) plus 6%, consistent with the Medicare Drug Fee Schedule. Injectable medications not available on the Medicare Drug Fee Schedule will be reimbursed at whole acquisition cost (WAC) plus 6.8%, or manual pricing based on the provider's actual acquisition cost. Practitioner administered injectable medications, including specialty drugs, purchased through the Federal Public Health Service's 340B Drug Pricing Program will be reimbursed at the 340B actual acquisition cost and no

more than the 340B ceiling price. When billing for medications administered during the course of a clinic visit, the physician must use the appropriate Health Care Common Procedure Coding System (HCPCS) procedure code for the medication, the correct number of units per the Health Care Common Procedure Coding System (HCPCS) description, the National Drug Code (NDC) of the drug administered, the National Drug Code (NDC) 'unit of measure', and the number of National Drug Code (NDC) units. A Current Procedural Terminology (CPT) code for the administration must also be submitted. When billing for medication which does not have a specific level I or II code, the physician must use a miscellaneous Health Care Common Procedure Coding System (HCPCS) code with the name and National Drug Code (NDC) number identifying the drug and include the dosage given. If this information is not with the claim, ~~the Department may return~~ the claim **may be returned** to the physician for completion or ~~pay the claim~~ **may be paid** at the lowest dosage manufactured for the specific drug. Payment for service is as described in this chapter.

**005.223(A) ALLERGY INJECTIONS.** ~~See payment limitations in this chapter.~~ Allergy injections must be administered under the supervision of a physician who can recognize early symptoms and signs of anaphylaxis and administer emergency medications where necessary. Allergy injections should be administered only in facilities equipped to treat anaphylaxis.

**005.232(B) VITAMIN B8-12 INJECTIONS.** ~~Nebraska Medicaid covers v~~ Vitamin B-12 injections **are covered** as specific or effective treatment for:

- (i) Gastrectomy;
- (ii) Idiopathic steatorrhea;
- (iii) Ileostomy;
- (iv) Internal cancers;
- (v) Macrocytic anemia;
- (vi) Megaloblastic anemia;
- (vii) During or after radiation therapy;
- (viii) Certain neuropathies;
- (ix) Pernicious anemia; and
- (x) Post-surgical and mechanical disorders.

**005.243 CHEMOTHERAPY.** ~~Nebraska Medicaid covers chemotherapy which has been provided and billed in accordance with this chapter.~~ Chemotherapy agents may be covered if all of the following criteria are met:

- (i) The agents are reasonable and medically necessary;
- (ii) The drug is approved by the Federal Drug Administration (FDA); and
- (iii) Nationally accepted oncology clinical guidelines have listings with the specific International Classifications of Diseases (ICD-10) diagnosis that is being treated for the drug or agent.

**005.254 IMMUNIZATIONS.** ~~Nebraska Medicaid covers r~~ Routine immunizations **are covered** for children, adolescents, and adults that are medically necessary according to the Advisory Committee on Immunization Practices' guidelines **requirements** that are effective the date the service is provided. Immunizations are available to children and adolescents from birth through age 20 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Vaccines for those **beneficiaries** individuals age 18 and younger are available through the Vaccine for Children (VFC) program. ~~The Department will not reimburse for a physician's private stock vaccine w~~ When the vaccine is available through the Vaccine for Children (VFC) program **and is a physician's private stock vaccine, it will not be reimbursed.**

005.265 LABORATORY SERVICES. Laboratory services may be provided in a physician's or group of physicians' private office, in a licensed and certified independent clinical laboratory, or in a hospital whose certification covers services performed in the laboratory.

005.265(A) PHYSICIAN'S OFFICE LABORATORY. A laboratory which a physician or a group of physicians maintains for performing diagnostic tests in connection with their own or the group practice is not considered an independent clinical laboratory.

005.265(B) LICENSED AND CERTIFIED INDEPENDENT CLINICAL LABORATORIES. A laboratory which is operated by or under the supervision of a hospital or the organized medical staff of the hospital which does not meet the definition of a hospital is considered to be an independent laboratory. A laboratory serving hospital inpatients and outpatients and operated on the premises of a hospital which meets the definition of a hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not classified as an independent clinical laboratory. The hospital's certification covers the services performed in this laboratory. ~~Nebraska Medicaid may cover~~ Laboratory tests which have been referred by one independent laboratory to another ~~may be covered.~~ ~~Nebraska Medicaid does not cover~~ Handling services for tests referred to a second laboratory ~~are not covered.~~ A specimen collection fee is not covered for samples where the cost of collecting the specimen is minimal, such as a throat culture, a routine capillary puncture, or a pap smear.

005.276 RADIOLOGY SERVICES. Claims for radiology procedures must have at least a provisional diagnosis or statement of symptoms. ~~The Department will not accept~~ Claims with a diagnosis of 'routine radiology' ~~are not accepted.~~ These services may be provided in a physician's or group of physicians' private office or a hospital whose certification covers the radiological services provided.

005.276(A) PHYSICIAN'S PRIVATE OFFICE. ~~Nebraska Medicaid covers~~ The total radiology procedure ~~is covered~~ when both the technical and professional components of medically necessary radiological procedures are performed in a physician's private office.

005.276(B) HOSPITAL RADIOLOGY SERVICES. ~~When a physician orders~~ Medically necessary radiological services ~~that are referenced in this title are covered when ordered by a physician and performed in a hospital,~~ ~~Nebraska Medicaid covers those services under 471 NAC 10. The Department does not reimburse~~ The private ordering physician ~~is not reimbursed~~ for interpreting radiology procedures performed outside their office.

005.276(C) MAMMOGRAMS. ~~Nebraska Medicaid covers~~ Mammograms ~~are covered~~ when provided based on a medically necessary diagnosis. In the absence of a diagnosis, ~~Nebraska Medicaid covers~~ mammograms provided according to the American Cancer Society's periodicity schedule ~~are also covered.~~

005.276(D) ULTRASOUND DIAGNOSTIC PROCEDURES. ~~Nebraska Medicaid covers~~ Ultrasound diagnostic procedures listed by Medicare under Category I ~~are covered.~~ The Department may review Claims for these procedures ~~may be reviewed~~ to ensure the techniques are medically appropriate and the general indications of Medicare's categories are met. Claims for uses other than those listed under Medicare's Category I will be reviewed before payment. ~~Nebraska Medicaid does not cover~~ Ultrasound procedures listed by Medicare under Category II ~~are not covered.~~

005.276(E) COMPUTERIZED TOMOGRAPHY (CT) SCANS. Nebraska Medicaid covers ~~d~~Diagnostic examinations of the head and of certain other parts of the body performed by computerized tomography (CT) scanners **are covered** when medical and scientific literature and opinion support the use of a scan for the condition, the scan is reasonable and necessary for the **beneficiary** individual, and the scan is performed on a model of computerized tomography (CT) equipment which meets Medicare's criteria for coverage.

005.276(E)(i) REASONABLE AND NECESSARY. To be determined reasonable and necessary for the **beneficiary** individual, the use of the computerized tomography (CT) scan must be medically appropriate considering the **beneficiary's** individual's symptoms and preliminary diagnosis. ~~The Department~~ **It may be determined** the use of a computerized tomography (CT) scan as the initial diagnostic test was not reasonable and necessary because it was not supported by the individual's **beneficiary's** symptoms and complaints stated on the claim form or electronic format. ~~The Department reviews c~~Claims for computerized tomography (CT) scans **are reviewed** for evidence of abuse, such as the absence of reasonable indications for the scans, an excessive number of scans, or unnecessarily expensive types of scans.

005.276(F) PORTABLE X-RAY SERVICES. Nebraska Medicaid covers ~~d~~Diagnostic x-ray services provided by a certified portable x-ray provider **are covered** when provided in a place of residence used as the **beneficiary's** individual's home and in nonparticipating institutions. These services must be performed under the **prescription** general supervision of a physician and ~~certain~~ conditions relating to health and safety must be met. Nebraska Medicaid also covers ~~d~~Diagnostic portable x-ray services **are also covered** when provided in participating skilled nursing facilities (SNF) under circumstances in which they cannot be covered as skilled nursing facility (SNF) services, such as those services not provided by the participating institution either directly or under arrangements which allow the institution to bill for the services. If portable x-ray services are provided in a participating hospital under arrangement, the hospital will bill for the service.

005.276(F)(i) COVERED PORTABLE X-RAY SERVICES. Nebraska Medicaid covers ~~t~~The following portable x-ray services **are covered**:

- (1) Skeletal films involving arms, legs, pelvis, vertebral column, and skull;
- (2) Chest films which do not involve the use of contrast media and are not used for routine screening or physical examinations; and
- (3) Abdominal films which do not involve the use of contrast media.

005.276(F)(ii) ELECTROCARDIOGRAMS. The taking of an electrocardiogram tracing by an approved provider of portable x-ray services may be covered as an 'other diagnostic test'.

005.287 HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES. Hospital diagnostic and therapeutic services are procedures performed to determine the nature and severity of an illness or injury, or procedures used to treat disease or disorders. Hospital diagnostic and therapeutic services include both inpatient and outpatient hospital services. Hospital diagnostic and therapeutic services are comprised of two distinct elements: the professional component and the technical component. Nebraska Medicaid may designate ~~e~~Other services **may be designated** as having professional and technical components when the services are identified.

005.287(A) PROFESSIONAL COMPONENT. The professional component of hospital diagnostic and therapeutic services includes those physician's services directly related to the medical care of the **beneficiary individual**. A physician includes not only a specialist but also a physician who normally performs or supervises these services for all inpatients and outpatients of a hospital, even though the physician does not otherwise specialize in this field.

005.287(A)(i) COVERAGE CONDITIONS. To be covered as a professional component, the physician's services must:

- (1) Be personally provided to an **individual beneficiary** by a physician;
- (2) Contribute directly to the diagnosis or treatment of an **individual beneficiary**;
- (3) Ordinarily require performance by a physician;
- (4) Be medically necessary; and
- (5) For anesthesiology, laboratory, or radiology services, meet the requirements previously set forth in this chapter.

005.287(B) TECHNICAL COMPONENT. The technical component of hospital diagnostic and therapeutic services is **comprised of two distinct elements**: ~~covered in accordance with 471 NAC 10-~~

- (i) **Physicians' professional services not directly related to the medical care of the beneficiary; and**
- (ii) **Hospital services.**

005.287(C) PRE-ADMISSION TESTING. ~~Nebraska Medicaid does not cover p~~Pre-admission testing performed in a physician's office which is performed solely to satisfy hospital pre-admission requirements **is not covered**.

005.287(D) RADIOLOGY AND PATHOLOGY. ~~Nebraska Medicaid covers m~~Medically necessary radiological and pathological services provided to inpatients and outpatients **are covered**. ~~Nebraska Medicaid covers o~~Only those services which are directly related to the **beneficiary's individual's diagnosis are covered**.

005.287(D)(i) OUTPATIENT DIAGNOSTIC SERVICES PROVIDED BY ARRANGEMENT. ~~Nebraska Medicaid covers m~~Medically necessary diagnostic services provided to an outpatient by arrangement **are covered**.

005.287(D)(ii) LABORATORY AND PATHOLOGY.

005.287(D)(ii)(1) PROFESSIONAL COMPONENT. ~~Nebraska Medicaid covers as a physician's service t~~The professional component of laboratory services provided by a physician to an **individual beneficiary is covered as a physician's service** only if the services meet the conditions of coverage previously outlined and are:

- (a) Anatomical pathology services; or
- (b) Consultative pathology services, which must:
  - (i) Be requested by the **individual's beneficiary's** attending physician;
  - (ii) Relate to a test result which lies outside the clinically significant normal or expected range in view of the **individual's beneficiary's** condition;
  - (iii) Result in a written narrative report included in the **individual's beneficiary's** medical record; and
  - (iv) Require the exercise of medical judgment by the consulting physician;or

- (v) ~~Services~~ **Be** performed by a physician in personal administration of test devices, isotopes, or other materials to an individual **beneficiary**.

005.287(D)(ii)(2) TECHNICAL COMPONENT. Clinical laboratory services do not require performance by a physician and are considered the technical component. There is no professional component for these services.

005.287(D)(ii)(3) ANATOMICAL PATHOLOGY SERVICES. Anatomical pathology services are services which ordinarily require a physician's interpretation. If these services are provided to hospital inpatients or outpatients, the professional and technical components must be separately identified for billing and payment.

005.287(D)(ii)(4) CLINICAL LABORATORY CONSULTATION. ~~Nebraska Medicaid covers a~~ **A** physician clinical laboratory consultation **is covered** if the service **consultation**:

- (a) Is requested by the individual's **beneficiary's** attending physician;
- (b) Relates to a test result which lies outside the clinically significant normal or expected range for the individual's **beneficiary's** condition;
- (c) Results in a written narrative report which is included in the **beneficiary's** individual's record; and
- (d) Requires the exercise of medical judgement by the consulting physician.

005.287(D)(iii) RADIOLOGY. All radiology services have a technical component and a professional component. The professional and technical component of hospital services must be separately identified for billing and payment.

005.287(D)(iii)(1) PROFESSIONAL COMPONENT. The professional component of radiology services provided by a physician to an individual **beneficiary** is covered as a physician's service when the services meet the previously outlined conditions of coverage and the services are identifiable, direct, and discrete diagnostic or therapeutic services to an individual **beneficiary**, ~~such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures.~~

005.287(D)(iii)(2) TECHNICAL COMPONENT. ~~The technical component of hospital diagnostic and therapeutic services is~~ **are services needed to produce the x-ray films or other items that are interpreted by the radiologist** ~~covered in accordance with 471 NAC 10.~~

005.298 NON-PHYSICIAN CARE PROVIDERS. ~~Nebraska Medicaid covers s~~ **S**ervices provided by non-physician care providers who have fulfilled all state and federal licensing, certification, and training requirements **are covered**, under the following conditions:

- (A) The non-physician care provider must meet the following definition: An individual trained to assist or act in the place of a physician, ~~such as physician assistant, medical specialty assistant, medical services assistant, clinical associate, surgical assistant, or graduate physician assistant who has completed a committee on allied health education and accreditation (CAHEA) accredited surgical residency program;~~
- (B) The service provided by the non-physician care provider must be within the scope of practice as defined by state law; and
- (C) The non-physician care provider must provide the services under a practice agreement between the non-physician care provider and their supervising physician and must be approved by the **Nebraska** Board of Medicine and Surgery ~~in the~~

Nebraska Department of Health and Human Services or the appropriate licensing agency in the state in which they provide the services.

005.3029 PHYSICIAN SERVICES IN SKILLED NURSING FACILITIES (SNF), INTERMEDIATE CARE FACILITIES (ICF) AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). The physician must complete, sign and date Form DM-5: Physician's Confidential Report prior to admission in a skilled nursing facility (SNF), intermediate care facility (ICF) or intermediate care facility for individuals with developmental disabilities (ICF/DD). Form DM-5: Physician's Confidential Report serves as the certification required by federal regulations. If the admission is a facility-to-facility transfer, local office staff will obtain a copy of the individual's annual history and physical, if it is current to the individual's condition within 30 days before the transfer and attach it to the signed and dated Form DM-5: Physician's Confidential Reports. Initial certifications for admission into nursing facilities (NF), intermediate care facilities (ICF), or intermediate care facilities for individuals with developmental disabilities (ICF/DD) are required. The physician must examine the individual beneficiary before completing the certification, within the following time frames:

- (1) SKILLED NURSING FACILITIES (SNF). The individual beneficiary must have a physical examination no later than two business days after admission unless an examination was performed within five days before admission; and
- (2) INTERMEDIATE CARE FACILITIES (ICF). The individual beneficiary must have a recent physical examination within 30 days before admission or the date eligibility was determined, or no later than two business days after admission or the date eligibility was determined.

005.3029(A) ANNUAL PHYSICAL EXAMINATION. Nebraska Medicaid requires aAll long-term care (LTC) facility residents are required to have an annual physical examination. The physician, based on their authority to prescribe continued treatment, determines the extent of the examination for individuals beneficiaries based on medical necessity. Nebraska Medicaid does not cover routine laboratory and radiology services which are not directly related to the individual's beneficiary's diagnosis and treatment are not covered; however, for the annual physical exam, a complete blood count (CBC), and urinalysis are not considered routine and are reimbursed based on the physician's orders when noted on the claim that these services were performed for an annual physical exam for a long-term care facility (LTC) nursing resident. The results of the examination must be recorded in the individual's beneficiary's medical record.

005.3029(B) PHYSICIANS' SERVICES FOR SKILLED NURSING FACILITY (SNF) RESIDENTS.

005.3029(B)(i) PHYSICIANS' VISITS. The physician must see the skilled nursing facility (SNF) resident whenever necessary, but at least once every 30 days for the first 90 days following admission. After the 90th day following admission, an alternate schedule for physician's visits not to exceed 60 days may be adopted if the attending physician determines, and justifies in the individual's beneficiary's medical record, the individual's beneficiary's condition does not require visits at 30-day intervals. The facility's Utilization Review Committee will approve the alternate schedule. At the time of each visit, the physician must document the visit in the individual's beneficiary's medical record and write and sign a progress note on the individual's beneficiary's condition.

005.3029(B)(ii) REVIEW OF PLAN OF CARE. The physician and facility staff involved in the **nursing facility** (SNF) resident's care will review each plan of care every 60 days. This should be done in conjunction with a physician's visit or recertification.

005.3029(B)(iii) RECERTIFICATION. For **skilled nursing facility** (SNF) residents, the physician, **or the physician's assistant (PA), or nurse practitioner (NP)** will recertify in writing the **individual's beneficiary's** continued need for the current level of care (LOC) every 30 days for the first 90 days, every 60 days thereafter, and at any time the **individual beneficiary** requires a different level of care (LOC). ~~The physician's assistant or nurse practitioner (NP) or physician's assistant (PA), may recertify the individual's need under the general supervision of a physician, may recertify the individual's beneficiary's need when the physician formally delegates this function to the physician's assistant.~~ The physician, the physician's assistant (PA), or nurse practitioner (NP) must sign, or stamp and initial, the recertification clearly identifying themselves. The recertification must also be dated at the time it is signed. Facility staff must maintain the recertification in the **beneficiary's** individual's medical record in the facility or building where the **beneficiary** individual resides.

005.3029(B)(iii)(1) ON-SITE RECERTIFICATION. The **recertifying practitioner** ~~physician~~ must record recertification accomplished by on-site visits to the facility in the **individual's beneficiary's** record.

005.3029(C) PHYSICIANS' SERVICES FOR RESIDENTS OF INTERMEDIATE CARE FACILITIES (ICF'S) AND INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED (ICF/DD'S).

005.3029(C)(i) PHYSICIAN'S VISITS. ~~The physician must see the intermediate care facility (ICF) resident whenever necessary, but at least once every 60 days, unless the physician determines the frequency is not necessary and establishes an alternate schedule not to exceed one year and records the reason in the medical record. The physician must actually see the individual beneficiary to claim the service. At the time of each visit, the physician must document the visit in the individual's beneficiary's medical record and write and sign a progress note on the individual's beneficiary's condition.~~

005.3029(C)(ii) REVIEW PLAN OF CARE. The interdisciplinary team, which includes the physician, must review each intermediate care facility (ICF) plan of care every 90 days. This should be done in conjunction with recertification and is not reimbursed separately.

005.3029(C)(iii) RECERTIFICATION. The physician, **physician's assistant (PA), or nurse practitioner (NP)** must recertify in writing the **individual's beneficiary's** continued need for the intermediate care facilities for the developmentally disabled (ICF/DD) level of care (LOC) at least once every 365 days, and at any time the **individual beneficiary** requires a different level of care. The extended recertification period in no way indicates one year is the appropriate length of stay for an **individual beneficiary** in an intermediate care facility (ICF) for the developmentally disabled (ICF/DD). The interagency team responsible for the **individual's beneficiary's** care determines the **beneficiary's** individual's length of stay. The physician's assistant (PA) or nurse practitioner (NP) may recertify the **individual's beneficiary's** need under the general supervision of a physician when the physician formally delegates this function to the

physician's assistant (PA) or nurse practitioner (NP). The physician, the physician's assistant (PA), or nurse practitioner (NP) must sign, or stamp and initial, the recertification clearly identifying themselves. The physician, physician's assistant (PA), or nurse practitioner (NP) must date the recertification at the same time it is signed. Facility staff must maintain the recertification in the beneficiary's individual's medical record in the facility or building where the beneficiary individual resides.

005.3029(C)(iii)(1) ON-SITE RECERTIFICATION. The recertifying physician practitioner must record recertification accomplished by on-site visits to the facility in the individual's beneficiary's record.

005.310 TELEPHONE CONSULTATIONS. ~~Nebraska Medicaid does not cover t~~Telephone calls to or from an individual beneficiary, pharmacy, nursing facility (NF) home, or hospital ~~are not covered.~~ Nebraska Medicaid may cover tTelephone consultations with another physician ~~may be covered~~ if the name of the consulting physician is indicated on or in the claim.

005.324 MEDICAL TRANSPLANTS. ~~Nebraska Medicaid covers t~~Transplants ~~are covered,~~ including donor services which are medically necessary and defined as non-experimental by Medicare. ~~Nebraska Medicaid may cover t~~Transplantation services ~~may be covered~~ when performed in a facility approved by Centers for Medicaid and Medicare (CMS) as meeting coverage criteria. Nebraska Medicaid is the payor of last resort, ~~see 471 NAC 3.~~ Nebraska Medicaid requires pPrior authorization of all transplant services ~~is required~~ before the services are provided. An exception may be made for emergency situations, in which case verbal approval is obtained and the notification of authorization is sent later.

005.324(A) SERVICES FOR A NEBRASKA MEDICAID-ELIGIBLE DONOR. ~~Nebraska Medicaid covers m~~Medically necessary services ~~are covered,~~ including laboratory tests directly related to the transplant, for the Nebraska Medicaid-eligible donor to a Nebraska Medicaid-eligible individual beneficiary. The services must be directly related to the transplant.

005.324(B) SERVICES FOR A NEBRASKA MEDICAID-INELIGIBLE DONOR. ~~Nebraska Medicaid covers m~~Medically necessary services ~~are covered,~~ including laboratory tests directly related to the transplant, for a Nebraska Medicaid-ineligible donor to a Nebraska Medicaid-eligible individual beneficiary. The services must be directly related to the transplant and must directly benefit the Nebraska Medicaid transplant beneficiary recipient. Coverage of treatment for complications related to the donor is limited to those which are reasonably medically foreseeable.

005.324(C) AMBULATORY ROOM AND BOARD. ~~Nebraska Medicaid may cover a~~Ambulatory room and board services ~~may be covered~~ for transplant patients for the individual beneficiary and an attendant, if necessary.

005.332 ITINERANT PHYSICIAN VISITS. ~~Nebraska Medicaid covers n~~Non-emergency physician visits provided in a hospital outpatient setting ~~are covered~~ if the services are:

- (A) Provided by an out-of-town specialist who has a contractual agreement with the hospital. ~~Medicaid does not consider g~~General practitioners or family practitioners ~~are not considered~~ to be specialists; and
- (B) Determined to have been provided in the most appropriate place of service in accordance with 471 NAC 2.

~~005.343~~ NURSE PRACTITIONER SERVICES (NP). Nebraska Medicaid covers nNurse practitioner (NP) services; **are covered** in accordance with the scope of practice applicable to their specific licensure designation.

~~005.354~~ DURABLE MEDICAL EQUIPMENT AND SUPPLIES. With certain exceptions, Nebraska Medicaid does not enroll hospitals, hospital pharmacies, long-term care (LTC) facilities, rehabilitation services or centers, or physicians **are not enrolled** as providers of durable medical equipment and medical supplies.

~~005.34(A)~~ INFANT APNEA MONITORS. Nebraska Medicaid covers rental of home infant apnea monitors for infants with medical conditions which require monitoring due to a specific medical diagnosis only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent or caregiver training must occur before placement of infant apnea monitor. In addition to the regulations outlined herein, apnea monitoring services must be provided in accordance with 471 NAC 7.

~~005.34(A)(i)~~ DOCUMENTATION REQUIRED AFTER INITIAL RENTAL PERIOD. Monitor rental exceeding the original two-month prescription period requires an updated physician's narrative report of patient progress and a statement of continued need to accompany the claim. A new progress report is required every two months. The report must include:

- ~~(1) The number of apnea episodes during the previous prescription period;~~
- ~~(2) The results of any tests performed during the previous prescription period;~~
- ~~(3) Additional length of time needed; and~~
- ~~(4) Any additional information the physician may wish to provide.~~

~~005.34(A)(ii)~~ PNEUMOCARDIOGRAMS. Pneumocardiograms are covered only when physician ordered to determine when the infant may be removed from the monitor. Payment for rental of an electrocardiogram (ECG) respirator recorder includes all accessories required to obtain a valid pneumocardiogram. Coverage of durable medical equipment does not include analysis and interpretation of tests, which is covered for the physician performing the service.

~~005.34(B)~~ HOME PHOTOTHERAPY. Nebraska Medicaid covers rental of home phototherapy (bilirubin) equipment for infants who require phototherapy when neonatal hyperbilirubinemia is the infant's sole clinical problem and only if prescribed by and used under the supervision of a physician. Prior authorization is not required for this service. In addition to the regulations outlined herein, home phototherapy services must be provided in accordance with 471 NAC 7.

~~005.34(B)(i)~~ LIMITATIONS ON COVERAGE OF HOME PHOTOTHERAPY SERVICES. Coverage of the rental of home phototherapy equipment does not include physician's professional services or laboratory and radiology services related to home phototherapy.

~~005.34(C)~~ AMBULATORY UTERINE MONITORS. Nebraska Medicaid covers rental of ambulatory uterine monitors. The monitor must be prescribed by and used under the supervision of a physician and provided by a medical supplier. Prior authorization is not required for this service. In addition to the regulations outlined herein, ambulatory uterine monitor services must be provided in accordance with 471 NAC 7.

~~005.34(C)(i) LIMITATIONS ON COVERAGE OF AMBULATORY UTERINE MONITORS. Nebraska Medicaid covers all equipment, supplies, and services necessary for the effective use of the monitor. This does not include medications or physician's professional services. Rental is allowable only when the individual is at home and appropriately using the monitor.~~

#### 005.365 ANESTHESIOLOGY.

~~005.365(A) PROFESSIONAL COMPONENT. Nebraska Medicaid covers, as a physician's service, t~~The professional component of anesthesiology services provided by a physician to an individual **beneficiary is covered as a physician's service** if the conditions in this chapter are met.

~~005.365(B) MEDICAL DIRECTION OF FOUR OR FEWER CONCURRENT PROCEDURES. The professional component for the physician's medical direction of concurrent anesthesiology services provided by qualified anesthetists, such as certified registered nurse anesthetists (CRNA), is covered as a physician's service when the services meet the requirements previously designated as conditions of coverage and the following additional requirements:~~

- (1) For each individual **beneficiary**, the physician:
  - (a) Performs and documents a pre-anesthetic examination and evaluation;
  - (b) Prescribes the anesthesia plan;
  - (c) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
  - (d) Ensures any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
  - (e) Monitors the course of anesthesia administration at frequent intervals;
  - (f) Remains physically present and available for immediate diagnosis and treatment of emergencies; and
  - (g) Provides indicated post-anesthesia care; and
- (2) The physician directs no more than four anesthesia procedures concurrently and does not provide any other services while directing the concurrent procedures.

~~005.365(B)(i) OTHER SERVICES PROVIDED WHILE DIRECTING CONCURRENT PROCEDURES. A physician who is directing concurrent anesthesia services for four or fewer surgical patients must not ordinarily be involved in providing additional services to other patients. The following situations are examples of services which do not constitute a separate service for determining medical direction:~~

- (a) Addressing an emergency of short duration in the immediate area;
- (b) Administering an epidural or caudal anesthetic to ease labor pain;
- (c) Periodic, rather than continuous, monitoring of an obstetrical patient;
- (d) Receiving patients entering the operating suite for the next surgery;
- (e) Checking or discharging patients in the recovery room; and
- (f) Handling scheduling matters.

~~005.365(B)(i)(1) SERVICES CONSIDERED A TECHNICAL COMPONENT. If the physician leaves the immediate area of the operating suite for longer than short durations, devotes extensive time to an emergency case, or is otherwise not available to respond to the immediate needs of surgical **beneficiaries** patients, the physician's services to the surgical **beneficiary** patient are supervisory in nature~~

and are considered a technical component; therefore, these services must be billed as the technical component by the hospital.

005.365(C) SUPERVISION MEDICAL DIRECTION OF MORE THAN FOUR CONCURRENT PROCEDURES. If the physician is involved in providing supervision for more than four concurrent procedures or is performing other services while directing concurrent procedures, the concurrent anesthesia services are covered as the technical component of the hospital services. The physician must ensure that a qualified individual performs any procedure in which the physician does not personally participate. The physician's personal services up to and including induction are considered the professional component.

005.365(D) STANDBY ANESTHESIA SERVICES. A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the individual's beneficiary's condition, making medical judgments regarding the individual's beneficiary's anesthesia needs, and is ready to furnish anesthesia services to a specific individual beneficiary who is known to be in potential need of services.

005.365(E) SERVICES OF CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA). When anesthesia services are provided by an anesthesiologist and a certified registered nurse anesthetist (CRNA) at the same time, Nebraska Medicaid will cover only those services provided by the anesthesiologist are covered. In the event multiple surgical procedures are performed at the same time, Nebraska Medicaid only covers only services provided by the certified registered nurse anesthetist (CRNA) services for the major procedure are covered. Nebraska Medicaid does not cover Certified registered nurse anesthetist (CRNA) services for secondary procedures are not covered.

005.376 FEEDING AND SWALLOWING CLINIC SERVICES. This service is covered for those individuals beneficiaries with dysphagia, a medical condition which makes feeding and swallowing difficult. The service is covered when the individual beneficiary is referred by a physician for a medical evaluation. The purpose of the evaluation is to assess the individual's beneficiary's current status and potential for improvement and to develop a plan of care for the individual beneficiary.

005.376(A) DEFINITIONS. For the purposes of feeding and swallowing clinic services, the following definitions will apply:

005.376(A)(i) SWALLOWING DISORDERS ASSESSMENT, COMPREHENSIVE. This includes, at a minimum, comprehensive evaluation by the occupational therapist (OT), speech-language pathologist, nurse, and nutritionist. The need for a psychologically evaluation is determined by intake information; if necessary, the psychologically evaluation is billed separately.

005.376(A)(ii) SWALLOWING DISORDER ASSESSMENT, EXTENDED. This includes, at a minimum, a comprehensive evaluation by the occupational therapist (OT) and extended evaluations by the speech-language pathologist, nurse, and nutritionist. The need for a psychologically evaluation is determined by intake information; if necessary, the psychologically evaluation is billed separately.

005.376(A)(iii) SWALLOWING DISORDER ASSESSMENT, BRIEF. The brief assessment includes approximately two hours of time for the occupational therapist (OT), speech-language pathologist, and nutritionist.

005.376(A)(iv) FOLLOW-UP VISIT, BRIEF. This includes a visit with two or more team members.

005.376(A)(v) FOLLOW-UP VISIT, EXTENDED. This includes a visit which involves four or more team members.

005.376(B) INITIAL EVALUATION. An initial evaluation must be performed by an interdisciplinary team, which, at a minimum, must include a nurse, occupational therapist (OT), speech-language pathologist, nutritionist, psychologist, and radiologist. The interdisciplinary team must be under the direction of a physician. After the initial visit, the interdisciplinary team formulates a formal written report and sends copies to the individual or family, the referring physician, and others designated by the individual beneficiary or family and by the Department Nebraska Medicaid. The team contacts the referring physician and, if appropriate, other medical professionals, to provide immediate feedback to the team on primary findings and recommendations.

005.376(C) FOLLOW-UP VISITS. Follow-up visits must be available in a frequency adequate to meet patient beneficiary needs and program objectives.

005.376(D) FOLLOW-UP CALLS. Follow-up telephone calls are made after the initial evaluation and are included in the cost of the evaluation, as follows:

- (i) Within 48 hours after the evaluation, a team member calls the beneficiary individual or family to answer questions and provide clarification, if needed, for any information presented during the initial visit;
- (ii) Two to four weeks after the initial visit, a follow-up call is made to ask about progress and problems in following the plan of care; and
- (iii) Ongoing telephone communication is maintained with the individual beneficiary or family and referring physician to facilitate implementation of the plan of care.

005.387 COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER. ~~Nebraska Medicaid covers c~~Comprehensive interdisciplinary treatment for an infant or child with a severe feeding disorder ~~is covered~~ when it impacts the infant's or child's ability to consume sufficient oral nutrition to maintain adequate growth or weight.

005.387(A) DEFINITIONS. For the purposes of comprehensive interdisciplinary treatment for a severe feeding disorder service, the following definitions will apply:

005.387(A)(i) DAY TREATMENT. Daily therapy, which occurs Monday through Friday, from approximately 8:30 am to 5:00 pm.

005.387(A)(ii) OUTPATIENT. Therapy one to two times per week for one to three hours per day.

005.398 TOBACCO CESSATION. ~~Nebraska Medicaid covers t~~Tobacco cessation services ~~are covered~~ as practitioner and pharmacy services, for individuals beneficiaries 18 years of age or older, under the following conditions:

- (A) Tobacco cessation services must be ordered by a physician or mid-level practitioner, ~~and provided in accordance with the provider requirements listed in 471 NAC 16;~~
- (B) Up to two tobacco cessation sessions may be covered in a 12-month period. A session is defined as medical encounters and drug products as listed below. Individual **Beneficiary** access to the Nebraska Tobacco Free Quitline will be unlimited;
- (C) Practitioner office visits:
  - (i) Individuals **Beneficiaries** must see their medical care provider for evaluation particularly for any contraindications for drug products and to obtain prescriptions if tobacco cessation products are needed; **and**
  - (ii) In addition to the evaluation, a total of four tobacco cessation counseling visits with a medical care provider or tobacco cessation counselor are covered for each tobacco cessation session. This may be a combination of intermediate or intensive tobacco cessation counseling visits;
- (D) Tobacco cessation products are covered ~~by Nebraska Medicaid~~ as a pharmacy service for those 18 years of age or older who require this particular assistance;
  - (i) Coverage of products used for tobacco cessation is limited to a maximum 90 days' supply in one tobacco cessation session. Up to two 90-day supplies may be covered in a 12-month period, beginning with the date the first prescription for the products is dispensed; and
  - (ii) Tobacco cessation products will only be covered when individuals **beneficiaries** are currently enrolled with, and actively participating in, the Nebraska Tobacco Free Quitline. Disenrollment or lack of active participation in the Nebraska Tobacco Free Quitline will result in discontinuation of Nebraska Medicaid coverage of tobacco cessation drug products; and
- (E) ~~Nebraska Tobacco Free Quitline:~~ Referral to the **Nebraska Tobacco Free** Quitline may be made by a medical professional or a self-referral.

005.4039 **ENDOMETRIAL ASPIRATION.** ~~Nebraska Medicaid covers v~~ Vacutage type or other endometrial aspiration or curettage **is covered**. The provider must submit the pathologist's report on the tissue with all claims for this service. For diagnoses of absent, delayed, or late menstruation, the physician must administer a pregnancy test to verify the individual **beneficiary** is not pregnant. When requested, the provider must submit copies of individuals' **beneficiaries'** medical records to **Nebraska Medicaid** ~~the Department~~.

005.410 **MEDICAL NUTRITION THERAPY FOR BENEFICIARIES INDIVIDUALS AGE 21 AND OLDER.** Medical nutrition therapy is available to individuals **beneficiaries** with medical needs which require nutritional assessment, intervention, and continued monitoring. ~~Nebraska Medicaid covers o~~ One-on-one medical nutrition therapy provided by a licensed medical nutritional therapist (LMNT) **is covered** for individuals **beneficiaries** age 21 and older under the following **guidelines requirements**:

- (A) The service is covered when the individual **beneficiary** is referred by a physician or nurse practitioner (NP). A nutritional assessment is done by **the an individual's beneficiary's** primary care provider. The diagnostic finding from the exam must indicate a nutritional problem or condition of such severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.;
- (B) Individuals **Beneficiaries** must meet at least one of the following medical conditions:
  - (i) Type I or Type II diabetes;
  - (ii) Current kidney disease; or
  - (iii) A kidney transplant in the last 36 months.;

- (C) Individuals **For beneficiaries** receiving dialysis in a dialysis facility **who** receive medical nutrition therapy as part of their overall dialysis care **in a dialysis facility**, medical nutrition therapy is not separately billable; **and**
- (D) Medical nutrition therapy includes the assessment, intervention, and counseling provided to prevent, improve, or resolve identified nutritional problems. Coverage of medical nutrition therapy allows for:
  - (i) Three hours in the first year;
  - (ii) Two hours in subsequent years; and
  - (iii) Additional hours are considered to be medically necessary and covered if the treating physician determines there is a change in medical condition, diagnosis, or treatment regimen which requires a change in medical nutrition therapy and orders additional hours during that episode of care. **The Department Nebraska Medicaid** may request periodic review of the services.

**006. NON-COVERED SERVICES.** **Non-covered services will not be covered by Nebraska Medicaid. Services are reviewed on a case-by-case basis to determine if they are covered.** ~~The services outlined in this section are specifically excluded from coverage by the Department. This is not intended to be an all-inclusive, or exhaustive, list of non-covered services.~~

~~006.01 SURGICAL PROCEDURES. Nebraska Medicaid does not cover:~~

- ~~(A) Acupuncture;~~
- ~~(B) Angiocardiography, single plane, supervision, and interpretation in conjunction with cineradiography or multi-plane, supervision, and interpretation in conjunction with cineradiography;~~
- ~~(C) Angiocardiography, utilizing CO<sub>2</sub> method, supervision, and interpretation only;~~
- ~~(D) Angiography, coronary, unilateral selective injection supervision, and interpretation only, single view unless emergency;~~
- ~~(E) Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;~~
- ~~(F) Ballistocardiogram;~~
- ~~(G) Basal metabolic rate (BMR);~~
- ~~(H) Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;~~
- ~~(I) Circumcision, female;~~
- ~~(J) Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;~~
- ~~(K) Extra-intra-cranial arterial bypass for stroke;~~
- ~~(L) Fabric wrapping of abdominal aneurysm;~~
- ~~(M) Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;~~
- ~~(N) Fascia lata by stripper when used as a treatment for lower back pain;~~
- ~~(O) Hypogastric or presacral neurectomy as an independent procedure;~~
- ~~(P) Hysterotomy, non-obstetrical, vaginal;~~
- ~~(Q) Icterus index;~~
- ~~(R) Ileal bypass or any other intestinal surgery for the treatment of obesity;~~
- ~~(S) Kidney decapsulation, unilateral and bilateral;~~
- ~~(T) Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;~~
- ~~(S) Ligation of internal mammary arteries, unilateral or bilateral;~~
- ~~(U) Ligation of thyroid arteries as an independent procedure;~~

- ~~(V) Nephropexy: fixation or suspension of kidney as an independent procedure, unilateral;~~
- ~~(W) Omentopexy for establishing collateral circulation in portal obstruction;~~
- ~~(X) Perirenal insufflation;~~
- ~~(Y) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;~~
- ~~(Z) Protein bound iodine (PBI);~~
- ~~(AA) Radical hemorrhoidectomy, whitehead type, including removal of entire pile-bearing area;~~
- ~~(BB) Refractive keratoplasty, includes keratomileusis, keratophakia, and radial keratotomy;~~
- ~~(CC) Reversal of tubal ligation or vasectomy;~~
- ~~(DD) Sex change procedures;~~
- ~~(FF) Solid organ transplants performed in a facility which is not included on the list of Medicare approved transplant programs;~~
- ~~(GG) Splanchnicectomy, unilateral or bilateral, when used as a treatment for hypertension;~~
- ~~(HH) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes or ovaries, one or both;~~
- ~~(II) Sympathectomy, thoracolumbar or lumbar, unilateral, or bilateral, when used as a treatment for hypertension; or~~
- ~~(JJ) Uterine suspension, with or without presacral sympathectomy.~~

006.02 OBSOLETE TESTS. Unless determined to be medically necessary by the physician performing the test and verified by the Department, Nebraska Medicaid does not cover the following obsolete diagnostic tests:

- ~~(A) Amylase, blood isoenzymes, electrophoretic;~~
- ~~(B) Chromium, blood;~~
- ~~(C) Guanase, blood;~~
- ~~(D) Zinc sulphate turbidity, blood;~~
- ~~(E) Skin test, cat scratch fever;~~
- ~~(F) Skin test, lymphopathia venereum;~~
- ~~(G) Circulation time, one test;~~
- ~~(H) Cephalin flocculation;~~
- ~~(I) Congo red, blood;~~
- ~~(J) Hormones, adrenocorticotropin quantitative animal tests;~~
- ~~(K) Hormones, adrenocorticotropin quantitative bioassay;~~
- ~~(L) Thymol turbidity, blood;~~
- ~~(M) Skin test, actinomycosis;~~
- ~~(N) Skin test, brucellosis;~~
- ~~(O) Skin test, leptospirosis;~~
- ~~(P) Skin test, psittacosis;~~
- ~~(Q) Skin test, trichinosis;~~
- ~~(R) Calcium, feces, 24-hour quantitative;~~
- ~~(S) Starch; feces, screening;~~
- ~~(T) Chymotrypsin, duodenal contents;~~
- ~~(U) Gastric analysis pepsin;~~
- ~~(V) Gastric analysis, tubeless;~~
- ~~(W) Calcium saturation clotting time;~~
- ~~(X) Capillary fragility test;~~
- ~~(Y) Colloidal gold;~~
- ~~(Z) Bendien's test for cancer and tuberculosis;~~

- (AA) Bolen's test for cancer; and
- (BB) Rehfuess test for gastric acidity.

006.013 SERVICES REQUIRED TO TREAT COMPLICATIONS OR CONDITIONS RESULTING FROM NON-COVERED SERVICES. Nebraska Medicaid may consider coverage of medically necessary services which are required to treat complications or conditions resulting from non-covered services. If the medically necessary services which are required to treat complications or conditions resulting from non-covered services are determined to be part of a previous non-covered service, such as an extension or a periodic segment of a non-covered service or follow-up care associated with it, the subsequent services will be denied.

006.024 SERVICES NOT REASONABLE AND NECESSARY. Nebraska Medicaid does not cover items and services which are not reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the function of a malformed body member are not covered.

006.035 SURGICAL ASSISTANT FEES. Nebraska Medicaid does not cover surgical assistance fees for the following procedures are not covered. Additional assistant fees may be determined to be noncovered during the utilization review process.

- (A) Laparoscopy, including laparoscopic tubal ligation;
- (B) Tonsillectomy, adenoidectomy, myringotomy;
- (C) Conservative or closed fracture care; and
- (D) Uncomplicated procedures of the integument.

006.046 EXPERIMENTAL AND INVESTIGATIONAL SERVICES. Nebraska Medicaid does not cover medical services which are considered investigational or experimental or which are not generally employed by the medical profession are not covered. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, the Department prohibits payment for these services is prohibited.

006.046(A) RELATED SERVICES. Nebraska Medicaid does not pay for associated or adjunctive services which are directly related to non-covered experimental or investigational services are not covered. The Department will pay for all medically necessary expenses incurred which are not directly related to the non-covered experimental or investigative services will be paid. Nebraska Medicaid may cover complications of non-covered services may be covered once the non-covered service is completed.

006.06(B) REQUESTS FOR MEDICAID COVERAGE. Requests for Nebraska Medicaid coverage for new services or those which may be considered experimental or investigational must be submitted in writing before providing the services, or in the case of medical emergencies, before submitting a claim. The request for coverage must include sufficient information to document the new service is not considered investigational or experimental for Department payment purposes. Reliable evidence must be submitted identifying the status on the new service with regard to the criteria listed below, cost benefit data, short and long term outcome data, patient selection criteria which is both disease or condition specific and age specific, information outlining the circumstances under which the service is considered the accepted standard of care, and any other information which would be helpful to the Department in deciding coverage issues. Additional information

~~may be requested by the Department. Requests must be submitted to the Department's Medical Director.~~

006.046(B)(i) INVESTIGATIONAL AND EXPERIMENTAL CRITERIA. Services may be deemed investigational or experimental by Nebraska Medicaid, which may convene ad hoc advisory groups of experts to review requests for coverage. A service is deemed investigational or experimental if it meets any one of the following criteria:

- (1) The Food and Drug Administration (FDA), or other governmental or regulatory authority, has not approved the service or treatment for general marketing to the public for the proposed use;
- (2) Reliable evidence does not lead to the conclusion that there is a consensus within the medical community that the service is a generally accepted standard of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease or proposed use and age group. Also, facility specific data, including short and long term outcomes, must be submitted to ~~the Department~~ **Nebraska Medicaid**;
- (3) The service is available only through an institutional review board (IRB) research protocol for the proposed use or subject to such an institutional review board (IRB) process; or
- (4) The service is the subject of an ongoing clinical trial which meets the definition of a phase I, phase II, or phase III clinical trial, regardless of whether the trial is actually subject to Food and Drug Administration (FDA) oversight and regardless of whether an institutional review board (IRB) process or protocol is required at any one particular institution.

006.046(C) DEFINITION OF CLINICAL TRIALS. For services not subject to Food and Drug Administration (FDA) approval, the following definitions apply:

- (i) PHASE I. Initial introduction of an investigational service into humans.
- (ii) PHASE II. Controlled clinical studies conducted to evaluate the effectiveness of the service for a particular indication or medical condition of the **individual beneficiary**; these studies are also designed to determine the short-term side effects and risks associated with the ~~new service~~ **clinical trial**.
- (iii) PHASE III. Clinical studies to further evaluate the effectiveness and safety of a service which is needed to evaluate the overall risk and benefit and to provide an adequate basis for determining patient selection criteria for the service as the recommended standard of care. These studies usually compare the ~~new service~~ **clinical trial** to the current recommended standard of care.

006.057 NON-COVERED PORTABLE X-RAY SERVICES. ~~Nebraska Medicaid does not cover~~ **The following portable x-ray services are not covered:**

- (A) Procedures involving fluoroscopy;
- (B) Procedures involving the use of contrast media;
- (C) Procedures requiring the administration of a substance to the **beneficiary individual** or injection of a substance into the **beneficiary individual** or special manipulation of the **beneficiary individual**;
- (D) Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require medical judgment be exercised;
- (E) Procedures requiring special technical competency or special equipment or materials;
- (F) Routine screening procedures; and

(G) Procedures which are not of a diagnostic nature.

~~006.08 NON COVERED DRUG SERVICES. Payment by Nebraska Medicaid will not be approved for:~~

- ~~(A) Requests for quantities not in compliance with 471 NAC 16;~~
- ~~(B) Experimental drugs or non-Food and Drug Administration (FDA) approved drugs;~~
- ~~(C) Drugs or items when the prescribed use is not for a medically accepted indication;~~
- ~~(D) Drugs or items prescribed or recommended for weight control or appetite suppression;~~
- ~~(E) Liquors;~~
- ~~(F) Drug Efficacy Study Implementation Program (DESI) drugs identified as less than effective (LTE) or identical, related, or similar (IRS) with an indicator value assigned by the Food and Drug Administration (FDA) of either five or six;~~
- ~~(G) Personal care items;~~
- ~~(H) Medical supplies and certain drugs for nursing facility and intermediate care facility for individuals with developmental disabilities (ICF/DD) residents, see 471 NAC 7 and 16;~~
- ~~(I) Over the counter (OTC) drugs not listed on the Nebraska Point of Sale System or on the Department's website;~~
- ~~(J) Drugs or items used for cosmetic purposes or hair growth;~~
- ~~(K) Baby foods or metabolic agents normally supplied by the Department, see 471 NAC 16 for exceptions;~~
- ~~(L) Drugs distributed or manufactured by certain drug manufacturers or labelers who have not agreed to participate in the drug rebate program;~~
- ~~(M) Products used to promote fertility;~~
- ~~(N) Medications dispensed as partial month fills for nursing facility or group home residents when dispensed by more than one pharmacy;~~
- ~~(O) Medications dispensed to replace products which have been recalled by the drug manufacturer;~~
- ~~(P) Drugs, items, or products of manufacturers or labelers which are identifiable as non-covered on the Nebraska Point of Sale System or on the Department's website;~~
- ~~(Q) Drugs, classes of drugs, or therapeutic categories of drugs which are Medicare Part D drugs and Medicare Part D covered supplies or equipment, for all persons eligible for benefits under Medicare Part D, whether or not such persons are enrolled into a Medicare Part D plan;~~
- ~~(R) Drugs or classes of drugs approved by the Food and Drug Administration (FDA) for treatment of sexual or erectile dysfunction, or drugs or classes of drugs which are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs which are approved by the Food and Drug Administration (FDA) for treatment of sexual or erectile dysfunction and for conditions other than treatment of sexual or erectile dysfunction and are prescribed for those other conditions may be covered, but Nebraska Medicaid may require prior authorization. See 471 NAC 16; and~~
- ~~(S) Automatic Refills, see 471 NAC 16.~~

~~006.069 INFLUENZA INJECTIONS IN LONG-TERM CARE (LTC) FACILITIES. No payment is made to a physician giving influenza injections in long-term care (LTC) facilities.~~

~~006.407 INJECTABLE ESTROGENS. Nebraska Medicaid does not pay for injectable estrogens for depression or osteoporosis associated with menopause are not covered.~~

~~006.1084~~ LIVER AND VITAMIN INJECTIONS. ~~Nebraska Medicaid does not pay for Liver and vitamin injections~~ **are not covered.**

~~006.0942~~ AUTOPSIES. Autopsies are a non-covered service under ~~Nebraska Medicaid.~~

**006.10 REQUESTS FOR NEBRASKA MEDICAID COVERAGE.** Requests for Nebraska Medicaid coverage for new or currently non-covered services or those which may be considered experimental or investigational must be submitted in writing before providing the services, or in the case of medical emergencies, before submitting a claim. The request for coverage must include sufficient information to document the new service is not considered investigational or experimental for Nebraska Medicaid payment purposes. Reliable evidence must be submitted identifying the status on the new service with regard to cost-benefit data, short- and long-term outcome data, patient selection criteria which is both disease or condition specific and age specific, information outlining the circumstances under which the service is considered the accepted standard of care, and any other information which would be helpful to Nebraska Medicaid in deciding coverage determination. Requests must be submitted to Nebraska Medicaid, and additional information may be requested. Nebraska Medicaid will make the final determination of coverage. The decision is final and is not appealable.

## **007. BILLING FOR PHYSICIAN SERVICES.**

~~007.01~~ GENERAL BILLING REQUIREMENTS. ~~Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter will govern.~~

**007.021** SPECIFIC BILLING REQUIREMENTS. Physicians' services must be billed on **the appropriate Nebraska Medicaid approved claim form** ~~Form CMS-1500~~ or the standard electronic **transaction form** ~~Health Care Claim: Professional transaction (ASC X12N 837).~~ Physicians' services must not be billed by a hospital. The physician or the physician's authorized agent must approve and date each paper claim. Approval of paper claims is indicated by the handwritten signature, signature stamp, or computer-generated signature of the physician or authorized agent. When a computer-encoded document or electronic transaction is used, ~~the Department may request~~ **the provider's source input documentation may be requested** from the provider for input verification and signature requirements. The physician or the physician's authorized agent must enter the physician's usual and customary charge for each procedure code on the claim.

**007.021(A)** PROCEDURE CODES. Physicians must use Healthcare Common Procedure Coding System (HCPCS) procedure codes when submitting claims to ~~the Department~~ **Nebraska Medicaid** for Medicaid services. ~~Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes used by the Department are listed in the Nebraska Medicaid Practitioner Fee Schedule.~~

**007.021(B)** PORTABLE X-RAY SERVICES. Claims for portable x-ray services must contain the name of the physician who ordered the service and a diagnosis of medical necessity.

**007.021(C)** SECOND SURGICAL OPINION. The second physician must bill Nebraska Medicaid with a Healthcare Common Procedure Coding System (HCPCS) consultation

procedure code indicating the level of the consultation and identifying the service as a second surgical opinion.

**007.021(D) PRENATAL, DELIVERY, AND POSTPARTUM CARE.** When billing Nebraska Medicaid for prenatal, delivery, and postpartum care, the provider must submit a claim at the time of delivery. When the primary physician does not participate in the total obstetrical care, the partial care may be billed separately from the delivery using the appropriate procedure codes. An explanation for the partial care must be submitted. Providers must use one procedure code but must provide individual dates of service on the claim. One charge is submitted covering all:

- (i) Routine prenatal care, vaginal delivery, and postpartum care; or
- (ii) Routine prenatal care, cesarean delivery, and postpartum care.

**007.01(D)(i) EXCEPTION.** Prenatal Plus Program (PPP) services outside of routine prenatal visits can be billed as they occur and are not submitted as a claim at the time of delivery.

**007.021(E) FRACTURE CARE.** Providers may claim subsequent replacement of cast or traction devices used during or after the period of follow-up care as an independent service using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code.

**007.021(F) PRACTITIONER ADMINISTERED MEDICATIONS.** When billing for medications administered during the course of a clinic visit, the physician must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for the medication, the correct number of units per the Healthcare Common Procedure Coding System (HCPCS) description, the National Drug Code (NDC) of the drug administered, the National Drug Code (NDC) unit of measure and the National Drug Code (NDC) number of units. A Current Procedural Terminology (CPT) code for the administration must also be submitted. When billing for medication which does not have a specific Level I or II code, the physician must use a miscellaneous Healthcare Common Procedure Coding System (HCPCS) code with the name and National Drug Code (NDC) number identifying the drug and include the dosage given. If this information is not with the claim, ~~the Department may return~~ the claim **may be returned** to the physician for completion or pay the claim at the lowest dosage manufactured for the specific drug.

**007.021(F)(i) CHEMOTHERAPY.** Providers must bill for chemotherapy using Healthcare Common Procedure Coding System (HCPCS) procedure codes for chemotherapy administration. The drug used must be identified and claimed separately on the claim using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code, the number of units per the Healthcare Common Procedure Coding System (HCPCS) description, the National Drug Code (NDC) of the drug administered, the National Drug Code (NDC) unit of measure, and the number of National Drug Code (NDC) units. For drugs which do not have a specific Healthcare Common Procedure Coding System (HCPCS) code, the provider must use a miscellaneous chemotherapy code. The provider must indicate on or in the claim the name of medication, the dosage administered, and the National Drug Code (NDC) number, unit of measure, and number of units.

**007.021(F)(ii) IMMUNIZATIONS.** When using Vaccine for Children (VFC) vaccines, only the administration is billed to Nebraska Medicaid by adding the appropriate

modifier to the vaccine code. The billed charge for the administration must not exceed the Vaccine for Children (VFC) federally determined state maximum for Nebraska.

007.021(G) PHYSICIAN'S OFFICE LABORATORY. If the services are provided in a physician's or group of physician's private office, payment may be claimed for the medically necessary services provided or supervised by the physician, using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code.

007.021(H) LICENSED AND CERTIFIED INDEPENDENT CLINICAL LABORATORY. The physician must indicate on or with the appropriate claim form or electronic format the fee for obtaining the specimen by venipuncture or catheterization is for tests performed outside his or her office and submit the name of the facility performing the tests on the claim.

007.021(I) BILLING FOR THE PROFESSIONAL AND TECHNICAL COMPONENTS OF HOSPITAL INPATIENT AND OUTPATIENT DIAGNOSTIC AND THERAPEUTIC SERVICES. The professional component of hospital diagnostic and therapeutic services must be billed as previously described except for facilities paid under an all-inclusive rate. The technical component of hospital diagnostic and therapeutic services must be billed by the hospital. A hospital may act as the billing agent for the physician's professional component. ~~The Department requires a~~ **A separate Nebraska Medicaid provider number is required** for each specialty for the hospital professional component. A separate provider agreement is required for each separate provider number. The professional component must be billed on the claim, using the appropriate provider number for the professional component of the appropriate specialty. Only one specialty, **and** one provider number, may be billed on each claim.

007.021(J) ANESTHESIOLOGY. The professional component must be claimed and must indicate actual time in one-minute increments. The physician's medical direction of four or fewer concurrent anesthesia procedures is considered a professional component.

~~007.02(J)(i) STANDBY ANESTHESIA. The professional component must be billed appropriately.~~

007.021(J)(ii) CLAIMS FOR PAYMENT. When a physician bills for anesthesia services, the physician must certify with the claim, as appropriate, that:

- (1) The services were personally provided by the physician to the ~~individual~~ **beneficiary**; or
- (2) When the physician provided medical direction for certified registered nurse anesthetist (CRNA) services, the number of concurrent services directed is indicated by the appropriate modifier.

007.021(J)(iii) STERILIZATION OR HYSTERECTOMY. To make payment for anesthesia services for sterilizations, a completed copy of **the appropriate Nebraska Medicaid approved consent form Form MMS-100: Sterilization Consent Form** must be on file with **Nebraska Medicaid** ~~the Department~~. For a hysterectomy, a completed copy of **the appropriate Nebraska Medicaid approved consent form Form MMS-104: Informed Consent for Hysterectomy**, signed and dated by the **beneficiary** individual stating she was made aware before the surgery that the surgery would result in sterility, must be on file with ~~the Department~~ **Nebraska Medicaid** before payment can

be made. Claims for these services must indicate actual time in one-minute increments.

007.021(J)(iii) CLAIMS FOR CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) SERVICES. Claims for certified registered nurse anesthetist (CRNA) services must be billed accordingly, except rural hospitals which have been exempted by their Medicare fiscal intermediary for certified registered nurse anesthetist (CRNA) billing must follow the Medicare billing requirements. ~~The Department does not make a~~Additional reimbursement **is not provided** for emergency and risk factors. When multiple surgical procedures are performed at the same time, the certified registered nurse anesthetist (CRNA) must bill only for the major procedure. ~~Medicaid does not make a~~Payment **is not made** for certified registered nurse anesthetist (CRNA) services for secondary procedures.

007.021(K) LABORATORY AND PATHOLOGY.

007.021(K)(i) INPATIENT HOSPITAL ANATOMICAL PATHOLOGY SERVICES. Payment for the technical component of anatomical pathology is included in the hospital's payment in accordance with 471 NAC 10. The pathologist must claim the professional component of anatomical pathology using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code and modifier. ~~Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(K)(ii)(1) EXCEPTION. If an anatomical pathology specimen is obtained from a hospital inpatient but is referred to an independent laboratory or the pathologist of a second hospital's laboratory, the independent laboratory, or the pathologist of the second hospital's laboratory to which the specimen has been referred may claim payment for the total service. ~~Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(K)(ii) OUTPATIENT HOSPITAL ANATOMICAL PATHOLOGY SERVICES. The hospital must claim the technical component according to **this title** 471 NAC 10. The pathologist must claim the professional component. ~~Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(K)(ii)(1) EXCEPTION. If an anatomical pathology specimen is obtained from a hospital outpatient and is referred to an independent laboratory or the pathologist of a second hospital's laboratory, the independent laboratory, or the pathologist of a second hospital's laboratory to which the specimen was referred may claim payment for the total service. ~~Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(K)(iii) NON-PATIENT ANATOMICAL PATHOLOGY SERVICES. A non-patient is an individual **beneficiary** receiving services who is neither an inpatient nor an outpatient. For specimens from non-patients referred to the hospital, the hospital must bill the total service. ~~Payment is made according to 471 NAC 10.~~

007.021(K)(iv) LEASED DEPARTMENTS. If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist must claim the total service. ~~Payment is made according to the Nebraska Medicaid~~

~~Practitioner Fee Schedule.~~ Leased department status has no bearing on billing for or payment of inpatient or outpatient anatomical pathology services.

007.021(K)(v) CLINICAL LABORATORY SERVICES. The professional and technical components of clinical laboratory services are not separately identified for billing and payment.

007.021(K)(vi) PHYSICIAN'S OFFICE OR INDEPENDENT LABORATORY. Clinical laboratory services performed in a physician's office or independent laboratory must be billed appropriately.

007.021(K)(vi)(1) CLINICAL LABORATORY CONSULTATION. The physician must claim a clinical laboratory consultation using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure codes.

007.021(L) RADIOLOGY. The professional component must be billed appropriately.

007.021(L)(i) INPATIENT RADIOLOGY SERVICES. Payment for the technical component of inpatient radiology services is included in the hospital's payment in accordance with 471 NAC 10. Physicians must bill the professional component of inpatient radiology services appropriately. ~~Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(L)(ii) OUTPATIENT RADIOLOGY SERVICES. The hospital must claim the technical component of outpatient radiology services on the appropriate **Nebraska Medicaid approved** claim form or electronic format. ~~Payment is made according to 471 NAC 10.~~ The physician must bill the professional component using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code with the modifier. ~~Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

~~007.02(L)(iii) NON-PATIENT RADIOLOGY SERVICES. A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. If a radiology procedure is performed for a non-patient, the hospital must claim the technical component. Payment is made according to 471 NAC 10. If the radiology department is leased and the service is provided to a non-patient, the radiologist must claim the total service. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(M) SERVICES PROVIDED BY PHYSICIAN ASSISTANTS (PA). Claims for services provided by physician assistants **(PA)** must be submitted on **the appropriate Nebraska Medicaid approved claim form** Form CMS-1500: Health Insurance Claim or the standard electronic Health Care Claim: Professional transaction **form** (ASC-X12N-837) under the physician assistant's **(PA)** provider group number.

007.021(N) PHYSICIAN SERVICES IN SKILLED NURSING FACILITY (SNF), INTERMEDIATE CARE FACILITY (ICF), AND INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). The physician may bill the Department **Nebraska Medicaid** for an annual nursing **facility (NF)** home physical exam service, regardless of the extent of the exam. Additionally, the physician may bill the

Department **Nebraska Medicaid** for the certification service. Payment is made according to the ~~Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(N)(i) ANNUAL PHYSICAL EXAMINATION. If the annual physical examination is performed solely to meet the requirement of **Nebraska Medicaid** the Department, the physician must submit the claim to **Nebraska Medicaid** the Department on **the appropriate Nebraska Medicaid approved claim form** Form CMS-1500: Health Insurance Claim or the standard electronic Health Care Claim: Professional transaction **format** (ASC X12N 837). ~~The Department limits reimbursement for this service to the amount allowed under the Nebraska Medicaid Practitioner Fee Schedule.~~

007.021(N)(ii) MEDICARE COVERAGE. If a physical examination is performed for diagnosis or treatment of a specific symptom, illness, or injury and the **beneficiary individual** has Medicare coverage, the physician must submit the claim through the usual Medicare process. This applies to all physicians' visits in a long-term care (**LTC**) facility.

007.021(N)(iii) PHYSICIANS' VISITS TO SKILLED NURSING FACILITY (SNF) RESIDENTS. When billing for a physician's visit, the physician must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for a nursing **facility (NF)** ~~home~~ visit.

007.021(N)(iv) ON-SITE RECERTIFICATION. ~~The physician is paid according to the Nebraska Medicaid Practitioner Fee Schedule.~~ The physician must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for nursing **facility (NF)** ~~home~~ visits when billing Nebraska Medicaid for this service.

007.021(N)(v) PHYSICIANS' VISITS TO INTERMEDIATE CARE FACILITY (ICF) AND INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) RESIDENTS. When billing for a physician's visit, the physician must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code. The physician must submit **the** following statements on or with the claim: "60-day (or alternate schedule) intermediate examination."

007.021(O) TRANSPLANT SERVICES. Physician services must be billed accordingly.

007.021(O)(i) BILLING FOR TRANSPLANT SERVICES PROVIDED TO A MEDICAID-INELIGIBLE DONOR. Claims for services provided to a Nebraska Medicaid-ineligible donor must be submitted under the Nebraska Medicaid-eligible ~~individual's~~ **beneficiary's** case number. There must be a notation with the claim indicating these services were provided to the Nebraska Medicaid-ineligible donor on the ~~individual's~~ **beneficiary's** behalf.

007.021(P) ITINERANT PHYSICIAN VISITS. The hospital room charge must be billed on the appropriate **Nebraska Medicaid approved** claim form or electronic format. The physician's service must be coded as an office visit and billed on the appropriate **Nebraska Medicaid approved** claim form or electronic format.

007.021(Q) CERTIFIED NURSE MIDWIFE (CNM) OR NURSE PRACTITIONER (NP) SERVICES. Claims for certified nurse midwife (CNM) services and nurse practitioner (NP) services must be submitted on the appropriate Nebraska Medicaid approved claim form Form CMS-1500-Health Insurance Claim according to instructions or on the appropriate electronic format transaction.

007.021(R) FEEDING AND SWALLOWING CLINIC SERVICES. The interdisciplinary team (IDT) services must be billed under the physician's provider number accordingly. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule. The physician services are billed under appropriate Current Procedural Terminology (CPT) codes.

007.02(S) COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER. Claims must be submitted accordingly.

## **008. PAYMENT.**

008.01 GENERAL PAYMENT REQUIREMENTS. Nebraska Medicaid will reimburse the provider will be reimbursed for services rendered in accordance with the applicable payment Nebraska regulations codified in 471 NAC 3. In the event individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter will govern.

### 008.02 SPECIFIC PAYMENT REQUIREMENTS.

008.02(A) REIMBURSEMENT. Nebraska Medicaid pays for covered physician services, except clinical laboratory services, are paid at the lower of the provider's submitted charge or the allowable amount for the procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.

008.02(A)(i) EXCEPTION. The Department may enter into an agreement with an out-of-state provider may enter into an agreement for a rate which exceeds the rate according to the Nebraska Medicaid Practitioner Fee Schedule only when the Department Nebraska Medicaid has determined the individual beneficiary requires specialized services which are not available in Nebraska and no other source of the specialized service can be found.

008.032(B) SITE OF SERVICE ADJUSTMENT. Nebraska Medicaid applies a site of service differential is applied which reduces the fee schedule amount for specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes when the service is provided in a facility setting. Based on the Medicare differential, the Department will reimburse specific Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) codes will be reimbursed with adjusted rates based on the site of service.

008.042(C) NON-PAYMENT OF OTHER PROVIDER PREVENTABLE CONDITIONS (OPPC). For physician and non-physician provider claims, payment will be denied for the following Other Provider Preventable Conditions (OPPCs):

- (i) Wrong surgical or other invasive procedure performed on an individual beneficiary;
- (ii) Wrong surgical or other invasive procedure performed on the wrong body part; and
- (iii) Wrong surgical or other invasive procedure performed on the wrong individual beneficiary.

008.052(D) SURGERY. The surgical procedure, including 14 days post-operative care, is reimbursed under a Healthcare Common Procedure Coding System (HCPCS) surgery procedure code. When multiple surgical procedures are done at one time, **Nebraska Medicaid** ~~the Department~~ reimburses the primary procedure according to the Nebraska Medicaid Practitioner Fee Schedule. Any secondary procedures which add significant time and complexity to patient care is reimbursed at one-half of the amount which would be paid if the procedure were the primary procedure.

008.052(A)(i) ASSISTANT SURGEON. When an assistant surgeon is required, reimbursement is made according to the Nebraska Medicaid Practitioner Fee Schedule. **Medicare's assistant surgery policy designation is followed.**

008.062(E) PRACTITIONER ADMINISTERED MEDICATIONS. ~~The Department will reimburse~~ **Practitioner administered injectable medications are reimbursed** at 100 percent of the Medicare Drug Fee Schedule plus an administration fee as listed. Injectable medications approved by **Nebraska Medicaid** ~~the Department~~ but not included on the Medicare Drug Fee Schedule will be reimbursed at the wholesale acquisition cost (WAC) plus 6.8 percent.

008.062(A)(i) ALLERGY INJECTIONS. When the cost of the medication is not listed in either the Drug Topics Red Book or The Blue Book, allergy injections are paid at the provider's submitted charge up to the maximum allowable dollar amount under the Nebraska Medicaid Practitioner Fee Schedule per injection which includes medication and injection fee. If the allergy medication is not prepared in the office of the physician administering the allergen and the administering physician incurs no expense for the supply or the supplier bills ~~the Department~~ **Nebraska Medicaid** separately, ~~the Department reimburses~~ the administering physician **is reimbursed** according to the **Nebraska Medicaid** Practitioner Fee Schedule for the injection fee. If the administering physician purchases the supply for administration in the office, the administering physician must not bill ~~the Department~~ **Nebraska Medicaid** for more than the cost of the supply. ~~The Department must not exceed~~ **The maximum allowable dollar amount under the Nebraska Medicaid Practitioner Fee Schedule must not be exceeded** in reimbursement per allergy injection, which includes the cost of the medication and the injection fee.

008.062(B)(ii) IMMUNIZATIONS. ~~The Department r~~ **Reimbursement is available for the provider's private stock vaccine and the administration fee for immunizations of adolescents age 19 and 20.**

008.072(F) LABORATORY AND PATHOLOGY.

008.07(A)2(F)(i) PHYSICIAN'S OFFICE OR INDEPENDENT LABORATORY. Payment is based on the Nebraska Medicaid fee schedule for clinical laboratory services to cover the total service, both professional and technical components.

008.07(A)(i)2(F)(i)(1) PHYSICIAN'S OFFICE LABORATORY. Payment for tests obtained in the physician's office but sent to an independent clinical laboratory or hospital for processing must be claimed by the facility performing the tests, using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code. The private physician's office may be reimbursed for the collection by venipuncture or catheterization for these procedures by using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code at the providers' submitted charge up to 100 percent of the Medicare clinical laboratory fee

schedule. ~~The Department does not reimburse~~ The private physician **is not reimbursed** for processing or interpreting tests performed outside their office.

008.07(B)2(F)(iii) CLINICAL LABORATORY SERVICES. Payment for clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization is made at the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare.

008.027(B)(i)(F)(ii)(4) LICENSED AND CERTIFIED INDEPENDENT CLINICAL LABORATORY. When a physician's private office sends the specimen to an independent clinical laboratory for processing, ~~the Department pays for~~ the procedure **is paid** directly to the independent clinical laboratory. ~~The Department does not reimburse~~ The laboratory **is not reimbursed** for collecting, handling, or drawing the specimen sent in by a physician's office. ~~The Department pays for~~ Specimens collected by venipuncture or catheterization obtained by the hospital or independent laboratory for hospital or independent laboratory patients **are paid for**. ~~The Department does not reimburse~~ The private physician **is not reimbursed** for processing or interpreting tests performed outside their office. ~~The Department does not allow~~ Reimbursement **is not allowed** for collection of specimens in a nursing **facility (NF) home** or long-term care **(LTC)** facility. If a physician performs some tests on a specimen and then sends the same specimen to an outside facility for additional procedures, the private physician may be reimbursed for the medically necessary procedures performed in their office plus a fee for drawing the specimen by venipuncture or obtaining urine by catheterization sent to a hospital or independent laboratory.

008.027(B)(ii)(F)(ii)(2) HOSPITAL CLINICAL LABORATORY SERVICES. ~~Payment is made to the hospital as follows.~~ There is no separate payment made to the pathologist for routine clinical laboratory services. To be paid, the pathologist must negotiate with the hospital to arrange a salary or compensation agreement.

- (a) INPATIENT SERVICES. Payment is included in **the** hospital's prospective payment rate ~~in accordance with 471 NAC 10;~~
- (b) OUTPATIENT SERVICES. Payment is made according to the fee schedule determined by ~~the Department~~ **Nebraska Medicaid**; and
- (c) NON-PATIENT SERVICES. Payment is made according to the fee schedule determined by ~~the Department~~ **Nebraska Medicaid**.

008.028(G) PROFESSIONAL COMPONENT OF HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES. ~~The Department pays for~~ The professional component of a physician's hospital diagnostic or therapeutic service **is paid** ~~as described previously.~~ Payment for the professional component of a radiology service provided in a hospital is made according to the ~~Nebraska Medicaid Practitioner Fee Schedule.~~ In the absence of available payment data ~~as described previously,~~ the Department pays for the professional component **is paid for** at a percentage of ~~the Department's~~ **the** allowable fee for the total procedure. The percentage is established by **Nebraska Medicaid** ~~the Department~~.

008.092(H) ANESTHESIOLOGY SERVICES. ~~The Department pays for~~ Covered anesthesiology services **are paid for** in accordance with the reimbursement rates previously described. ~~The Department does not make a~~ Additional reimbursement **is not made** for emergency and risk factors.

~~008.02(H)(i) PAYMENT FOR CERTIFIED REGISTERED NURSE ANESTHETISTS SERVICES.~~ These services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

~~008.1002(I)~~ **PAYMENT FOR SERVICES PROVIDED BY PHYSICIAN ASSISTANTS (PA).** Payment to physician assistants (PA) is made to the physician provider group number with whom the physician assistant (PA) is enrolled. When payment is made to the physician group, the physician is responsible for payment to the physician assistant (PA). ~~The Department Payments~~ will not make payments be made to physician's assistants (PA) who are employed by a hospital.

~~008.1102(J)~~ **PAYMENT FOR TRANSPLANT SERVICES.** The provider must submit, at the request of the Department **Nebraska Medicaid**, any medical documentation from the individual's **beneficiary's** record to support and substantiate claims submitted to the Department **Nebraska Medicaid** for payment.

~~008.02(J)(i) HOSPITAL SERVICES.~~ For information on payment of inpatient and outpatient hospital services in accordance with 471 NAC 10.

~~008.11(A)02(J)(ii)~~ **PHYSICIAN SERVICES TRANSPLANT SURGEON SERVICES.** ~~Surgeon services will be paid according to the Nebraska Medicaid Practitioner Fee Schedule.~~ This fee will include two weeks' routine post-operative care by the designated primary surgeon. Payment for routine post-operative care will not be made to other members of the surgical team. Services provided after the two-week post-operative period may be billed on a fee-for-service basis.

~~008.1202(K)~~ **ITINERANT PHYSICIAN VISITS.** The physician will be paid at the rate for the appropriate level of office visit.

~~008.1302(L)~~ **CERTIFIED NURSE MIDWIFE (CNM) SERVICES.** Payment for **certified** nurse midwife (CNM) services is made to the **certified nurse midwife (CNM) or the physician** group with whom the **certified** nurse-midwife (CNM) has a practice agreement.

~~008.1402(M)~~ **COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER.**

~~008.14(A)02(M)(i)~~ **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 scheduled amounts for covered services provided by Nebraska Medicaid enrolled licensed practitioners.

~~008.14(B)02(M)(ii)~~ **PEDIATRIC FEEDING DISORDER CLINIC OUTPATIENT TREATMENT.** Pediatric feeding disorder clinic outpatient treatment for medically necessary services is reimbursed at the appropriate fee schedule amount for a physician consultation for covered services provided by Nebraska Medicaid enrolled licensed practitioners.

**009. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP).**

009.01 GENERAL REQUIREMENT. Each provider prescribing a controlled substance in Nebraska to a Nebraska Medicaid client beneficiary must check the prescription drug monitoring program (PDMP) established under Nebraska statutes Neb. Rev. Stat. § 71-2454 before prescribing a schedule II medication and at dosage adjustment. The pProvider may delegate checking of the prescription drug monitoring program (PDMP) to a delegate as defined in Nebraska statutes Neb. Rev. Stat. § 71-2454 (14)(e).

009.02 EXCEPTION. Good faith exceptions must be documented in the client's beneficiary's medical record and provided upon request to the Department Nebraska Medicaid. These requirements do not include a prescription to a client beneficiary as set forth under federal statutes 42 U.S.C. 1396w-3a and to a resident of a facility where schedule II medications are dispensed to a client beneficiary through a single pharmacy.