NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

September 22, 2025

James G. Scott, Director
Centers for Medicare & Medicaid Services
Kansas City Regional Operations Group
Division of Medicaid Field Operations-North
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

RE: Nebraska State Plan Amendment NE 25-0013

Dear Mr. Scott:

Enclosed please find the above referenced amendment to the Nebraska Medicaid State Plan regarding state fiscal year 2026 outpatient and professional rates.

The Division of Medicaid and Long-Term Care sent notice on May 30, 2025 (attached) to the federally recognized Native American Tribes and Indian Health Programs within the State of Nebraska to discuss the impact the proposed state plan amendment might have, if any, on the Tribes. No comments were received.

If you have content questions, please feel free to contact Jeremy Brunssen at jeremy.brunssen@nebraska.gov or 402-540-0380. For submittal questions, please contact Dawn Kastens at dawn.kastens@nebraska.gov or 531-893-3379.

Sincerely,

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

cc: Tyson Christensen

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 25 — 0013

2. STATE: NE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT ☒ XIX ☐ XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 4.19-B: Item 1, Pg 1; Item 2a, Pgs 1, 3-4; Item 3, Pgs 1-3; Item 4b, Pgs 1-3; Item 4c, Pgs 1-2; Item 5, Pgs 1-2; Item 6a, Pg 1-2; Item 6b, Pgs 1-2; Item 6c, Pgs 1-2; Item 6d, Pg 1; Item 7, Pg 1; Item 7, Pg 1a; Item 7, Pg 2; Item 7c, Pg 1; Item 8; Item 9, Pgs 1, 3-5; Item 10, Pg 1; Item 11a, Pgs 1-2; Item 11b, Pgs 1-2; Item 11c, Pgs 1-2; Item 12a, Pg 1; Item 12b; Item 12c; Item 12d; Item 13b, Pg 1; Item 13c, Pg 1; Item 13d; Item 13d, Pg 1a; Item 13d, Pg 1b; Item 17; Item 20, Pgs 1-2; Item 21, Pgs 1-2; Item 23; Item 24a; Item 26; Item 27; Item 29; and Supplement 3 to 4.19-B, Pg 2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19-B: Item 1, Pg 1; Item 2a, Pgs 1, 3-4; Item 3, Pgs 1-3; Item 4b, Pgs 1-3; Item 4c, Pgs 1-2; Item 5, Pgs 1-2; Item 6a, Pg 1-2; Item 6b, Pgs 1-2; Item 6c, Pgs 1-2; Item 6d, Pg 1; Item 7, Pg 1; Item 7, Pg 1a; Item 7, Pg 2; Item 7c, Pg 1; Item 8; Item 9, Pgs 1, 3-5; Item 10, Pg 1; Item 11a, Pgs 1-2; Item 11b, Pgs 1-2; Item 11c, Pgs 1-2; Item 12a, Pg 1; Item 12b; Item 12c; Item 12d; Item 13b, Pg 1; Item 13c, Pg 1; Item 13d; Item 13d, Pg 1a; Item 13d, Pg 1b; Item 17; Item 20, Pgs 1-2; Item 21, Pgs 1-2; Item 23; Item 24a; Item 26; Item 27; Item 29; and Supplement 3 to 4.19-B, Pg 2

9. SUBJECT OF AMENDMENT
State Fiscal Year 2026 Outpatient and Professional Rates

10. GOVERNOR'S REVIEW *(Check One)*
- ○ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ○ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ○ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ◉ OTHER, AS SPECIFIED: Governor has waived review

11. SIGNATURE OF STATE AGENCY OFFICIAL
Drew Gonshorowski

12. TYPED NAME
Drew Gonshorowski

13. TITLE
Director, Division of Medicaid & Long-Term Care

14. DATE SUBMITTED
September 22, 2025

15. RETURN TO
Dawn Kastens
Division of Medicaid & Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

***FOR CMS USE ONLY***

16. DATE RECEIVED

17. DATE APPROVED

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2025, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program.

The fee schedule amounts for Injectables are based on 100% Medicare Drug fee schedule. The Department shall update the Injectables Fee Schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services. Injectable medications approved by the Medicaid Medical Director but not included on the Medicare Drug Fee Schedule will be reimbursed at the estimated acquisition cost (EAC) used to reimburse pharmacy claims.
The agency's fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date.
Payment methods for each service are defined in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates, as referenced below.

| **Service** | **Attachment** | **Effective Date** |
|---|---|---|
| ANESTHESIA | ATTACHMENT 4.19-B<br>Item 6d | July 1, 2024 |
| PRTF | ATTACHMENT 4.19-A<br>Page 30 | July 1, 2025 |

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

Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after July 1, 2025, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Ninety percent (93%) of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on Form CMS-1450 (UB-04).

The effective date of the cost-to-charges percentage is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on Form CMS-1450 (UB-04) in a summary bill format. Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services based on the fee schedule determined by Medicare.

Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 2016, payment for outpatient services of a CAH is one hundred percent (100%) of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. Nebraska Medicaid will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory services, that were previously paid for under those methods. Payment for these and other outpatient services will be made at one hundred percent (100%) of the reasonable cost of providing the services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, Nebraska Medicaid will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services.

Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio.

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

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

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

OUTPATIENT HOSPITAL SERVICES

Nebraska Medicaid pays for covered psychiatric partial hospitalization services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Mental Health and Substance Use Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
    a. The unit value multiplied by the conversion factor;
    b. The invoice cost (indicated as "IC" in the fee schedule);
    c. The maximum allowable dollar amount; or
    d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of psychiatric partial hospitalization services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for psychiatric partial hospitalization services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the EAPG Base Rates fee schedule for the specific program and year.

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

OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for anatomical laboratory services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician or Clinical Laboratory Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for anatomical laboratory services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

Clinical Diagnostic Laboratory Services

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

The fee schedule amounts for Clinical Laboratory services are based on 100% Medicare Clinical Laboratory Fee Schedule. The Department shall update the Clinical Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

X-Ray Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays a claim for both the technical and professional components of x-ray services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year. Updates are adjusted based on the Medicare fee schedule.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency’s rates were set as of July 1, 2025, and are effective for radiology services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

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

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

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

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

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

For services reimbursed under the Nebraska Medicaid Practitioner Fee Schedule, Nebraska Medicaid pays for EPSDT services (except for clinical diagnostic laboratory services) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Mental Health and Substance Use Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance use services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for EPSDT substance use services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2025, and are effective for EPSDT services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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

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

Other Licensed Practitioners: Licensed Alcohol and Drug Counselor (LADC)
Rehabilitation Services - 42 CFR 440.130(d): Day Treatment/Intensive Outpatient Service by Direct Care Staff; Community Treatment Aide; Professional Resource Family Care; Therapeutic Group Home; Multisystemic Therapy; Functional Family Therapy; and Peer Support.

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance use services. The agency's fee schedule rate was set as of July 1, 2025, and is effective for mental health and substance use services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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

FAMILY PLANNING SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for family planning services and supplies for individuals of child-bearing age at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for family planning services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

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

PHYSICIANS' SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for covered physicians' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule); or
   c. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. Exception: The Director of the Division of Medicaid and Long-Term Care or designee may enter into an agreement for a negotiated rate with an out-of-state provider which will be based on a percentage of billed charges, not to exceed 100%, only when the Medical Director of the Division has determined that:
   a. The client requires specialized services that are not available in Nebraska; and
   b. No other source of the specialized service can be found.

The following is a listing of specialized physician services that have been previously rendered by out-of-state providers:

a. lung transplants; and
b. pediatric heart transplants.

Note: The above listing is not all-inclusive of the specialized physician services that will be reimbursed via negotiated rates in the future, as it is based on previous experience.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physicians' services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for physician services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

Physicians and non-physician care providers are subject to a site-of-service payment adjustment. A site-of-service differential that reduces the fee schedule amount for specific CPT/HCPCS codes will be applied when the service is provided in the facility setting. Based on the Medicare differential, Nebraska Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site-of-service.

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

SMOKING CESSATION

Smoking cessation services rendered via common procedural terminology (CPT) codes 99406 and 99407 are reimbursed on a fee schedule.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for smoking cessation services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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

PODIATRISTS' SERVICES

Nebraska Medicaid pays for covered podiatry services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Podiatry Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount;
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for podiatrists' services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Providers will be notified of changes and their effective dates.

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

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

OPTOMETRISTS' SERVICES

Nebraska Medicaid pays for covered optometrists' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Visual Care Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for optometrists' services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

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

CHIROPRACTIC SERVICES

Nebraska Medicaid pays for covered chiropractic services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Chiropractic Fee Schedule in effect for that date of service.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for chiropractic services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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CERTIFIED REGISTERED NURSE ANESTHETISTS

The Nebraska Medical Assistance Program calculates payment for CRNA/AA services as follows: The total of the units assigned to the CPT/ASA procedure plus the appropriate number of time units are multiplied by the appropriate conversion factor for medically directed or non-medically directed services. This amount must not exceed the amount allowable for physicians' services for the procedure. These services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

When anesthesia services are provided by an anesthesiologist and a CRNA/AA at the same time, Nebraska Medicaid will make payment only for those services provided by the anesthesiologist.

Nebraska Medicaid does not make additional reimbursement for emergency and risk factors.

Nebraska Medicaid does not make payment for CRNA/AA services for secondary procedures. When multiple surgical procedures are performed at the same time, Nebraska Medicaid pays for only the major procedure.

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

SMOKING CESSATION

Smoking cessation services rendered via common procedural terminology (CPT) codes 99406 and 99407 are reimbursed on a fee schedule.

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

HOME HEALTH SERVICES

Nebraska Medicaid pays for medically prescribed and Department approved home health agency services provided by Medicare-certified home health agencies. The Department may request a cost report from any participating agency.

For dates of service on or after July 1, 1990, Medicaid pays for home health agency services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service.

Payment for supplies normally carried in the nursing bag and incidental to the nursing visit is included in the per visit rate. Medical supplies not normally carried in the nursing bag are provided by pharmacies or medical suppliers who bill Medicaid directly. Under extenuating circumstances, the home health agency may bill for a limited quantity of supplies.

Nebraska Medicaid applies the following payment limitations:
Brief services are performed by a home health or private-duty nursing service provider to complete the client’s daily care in a duration of 15 minutes to two hours per visit, when medically necessary. The services may be divided into two or more trips.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency’s rates were set as of July 1, 2025, and are effective for home health services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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## HOME HEALTH SERVICES

A nurse practitioner, physician assistant, or clinical nurse specialist can order home health services and certify the home health agency's plan of care. Extended Services are performed by a home health or private-duty nursing service provider when the client's needs cannot be appropriately met within the Brief Service limitation of two hours or less.

Medicaid applies the following payment limitations to nursing services (RN and LPN) for adults age 21 and older:

a. Per diem reimbursement for nursing services for the care of ventilator-dependent clients are paid at the lower of:
   1. The provider's submitted charge;
   2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service; or
   3. The average ventilator-dependent per diem of all Nebraska nursing facilities which are providing that service. This average per diem shall be computed using nursing facility's ventilator rates which are effective July 1 of each year, and are applicable for that state fiscal year period.

b. Per diem reimbursement for all other in-home nursing services are paid at the lower of:
   1. The provider's submitted charge;
   2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service; or
   3. The Extensive Services 2 case-mix reimbursement level. This average shall be computed using the Extensive Services 2 case-mix nursing facility rates which are effective July 1 of each year, and applicable for that state fiscal year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30 day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.) When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for home health services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES FOR SUITABLE USE IN THE HOME

Nebraska Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid DMEPOS Fee Schedule
   in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. For DMEPOS items associated with Section 1903(i)(27) of the Social Security Act, amended by Section 5002 of the 21 Century Cures Act, and identified by the Centers of Medicare and Medicaid Services (CMS) as covered by Medicare, Medicaid will pay the lower of the following: (1) The Medicare DMEPOS fee schedule rate for Nebraska geographic, non-rural areas, set as of January 1 of each year, which will be reviewed on a quarterly basis and updated as Medicare updates the fee schedule; (2) the Medicare competitive bidding program rate for the specific item of DME, or (3) the provider's billed charges.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for medical supplies, equipment, and applications services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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PRIVATE DUTY NURSING SERVICES

Payment for approved nursing services will be the lower of:

1. The submitted charge; or
2. The maximum allowable fee as established by the Department.

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

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CLINIC SERVICES

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

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Mental Health and Substance Use Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Mental Health and Substance Use Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025, and are effective for clinic services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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

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Ambulatory Surgical Centers:

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

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

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

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

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

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

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

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

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pediatric feeding disorder services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for pediatric feeding disorder services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Pediatric Feeding Clinics' fee schedule for the specific program and year.

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DENTAL SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for dental services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Dental Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for dental services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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PHYSICAL THERAPY

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for physical therapy services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physical Therapy and Occupational Therapy Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for physical therapy services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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OCCUPATIONAL THERAPY

Nebraska Medicaid pays for occupational therapy services provided by independent providers at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physical Therapy and Occupational Therapy Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" – by report or "RNE" - rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for occupational therapy services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST)

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for services for individual with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Speech Pathology and Audiology Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for services for individuals with speech, hearing, and language disorders on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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Professional Dispensing Fees

Professional Dispensing Fee: A professional dispensing fee of $10.50 shall be assigned to each claim payment based on the lesser of methodology described below.

PRESCRIBED DRUGS (Continued)

Cost Limitations: The Nebraska Medicaid Drug Program is required to reimburse ingredient cost for covered outpatient legend and non-legend drugs at the lowest of:

Brand Drugs

a. The usual and customary charge to the public, or;
b. The National Average Drug Acquisition cost (NADAC), plus the established professional dispensing fee, or;
c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee, or;
d. The calculated State Maximum Allowable Cost (SMAC) plus the established professional dispensing fee.

The FUL or SMAC limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the usual and customary charge or NADAC will be the maximum allowable cost.

Generic Drugs

a. The usual and customary charge to the public, or;
b. The National Average Drug Acquisition cost (NADAC), plus the established professional dispensing fee, or;
c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee, or;
d. The calculated State Maximum Allowable Cost (SMAC) plus the established professional dispensing fee.

Backup Ingredient Cost Benchmark

If NADAC is not available, the allowed ingredient cost shall be the lesser of Wholesale Acquisition Cost (WAC) + 0%, State Maximum Allowable Cost (SMAC) or ACA Federal Upper Limit plus the established professional dispensing fee.

Specialty Drugs

Specialty drugs shall be reimbursed at NADAC plus the established professional dispensing fee. If NADAC is not available, then the Backup Ingredient Cost Benchmark will apply.

340B Drug Pricing Program

Covered legend and non-legend drugs, including specialty drugs, purchased through the Federal

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DENTURES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for dentures at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Dental Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for denture services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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PROSTHETIC DEVICES

Nebraska Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid DMEPOS Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. For DMEPOS items associated with Section 1903(i)(27) of the Social Security Act, amended by Section 5002 of the 21 Century Cures Act, and identified by the Centers of Medicare and Medicaid Services (CMS) as covered by Medicare, Medicaid will pay the lower of the following: (1) The Medicare DMEPOS fee schedule rate for Nebraska geographic, non-rural areas, set as of January 1 of each year, which will be reviewed on a quarterly basis and updated as Medicare updates the fee schedule; (2) the Medicare competitive bidding program rate for the specific item of DME, or (3) the provider's billed charges.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for prosthetic device services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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EYEGLASSES

Nebraska Medicaid pays for covered eyeglasses at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Visual Care Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" by report or "RNE" rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for eyeglass services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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SCREENING SERVICES

Nebraska Medicaid pay for covered screening services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for screening services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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PREVENTIVE SERVICES

MEDICAL NUTRITION THERAPY/LACTATION COUNSELING SERVICES

Nebraska Medicaid pays for Medical Nutrition Therapy/Lactation Counseling services at the lower of:

1. The provider's submitted charge; or
2. The maximum allowable fee established by the Department.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medical Nutrition Therapy/Lactation Counseling Services. The agency's fee schedule rate for nutritional services was set as of January 1, 2025 and is effective for services provided on or after that date. All rates are published on the Physician Services Fee Schedule at https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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COMMUNITY-BASED COMPREHENSIVE PSYCHIATRIC REHABILITATION AND SUPPORT SERVICES PROGRAM

The Department pays separate rates for each community-based psychiatric rehabilitation and support service.

For Community Support, the unit of service is 15 minutes.
For Day Rehabilitation, the unit of service is a day of participation (five or more hours).
Note: Providers may bill for Day Rehabilitation services which do not meet the five hour minimum for a full day. The unit of service is 15 minutes with a minimum of twelve units of service provided up to a maximum of 19 units of service.
For Psychiatric Residential Rehabilitation, the unit of service is a day in residence (room and board is not included in the rate).
For Peer Support, the unit of service is 15 minutes.

Rates are reviewed annually based on audits and actual cost information submitted by each provider. The review is used as the basis for establishing a statewide fee schedule for each of the four services. Rates will not exceed the average statewide actual cost of providing rehabilitation services.

The Nebraska Medicaid Mental Health and Substance Use Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates for Community-Based Comprehensive Psychiatric Rehabilitation and Support services were set as of September 1, 2020, and are effective on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

The State assures that rehabilitative services are not provided in institutions for mental diseases (IMD).

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

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

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SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION

Medicaid has researched the cost of an existing similar service to develop a comparable rate. Costs for treatment and rehabilitation services are contained in the Medicaid rate. The rate does not include room and board. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Secure Psychiatric Residential Rehabilitation Services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for secure psychiatric residential rehabilitation services provided on or after that date. All rates are published at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

The State Medicaid agency will have an agreement with each entity receiving payment under Secure Psychiatric Residential Rehabilitation services that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate,
- Cost information by practitioner type and by type of service actually delivered within the services unit,
- Provider's annual utilization data and cost information shall support that the required type, quantity and intensity of treatment services are delivered to meet the medical needs of the clients served. Medicaid Agency or its designee may further evaluate through on site or post pay review of the treatment plans and the specific services delivered as necessary to assure compliance.

COMMUNITY SUPPORT SERVICES

Community Support Services shall be reimbursed on a direct service by service basis and billed in 15 minute increments up to a maximum of 144 units per 180 days.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of community support services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for community support services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

This rate will be the same for quasi-governmental and private providers of community support service.

The rate includes all indirect services and collateral contacts that are medically necessary rehabilitative related interventions.

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PEER SUPPORT

Peer Support shall be reimbursed on a direct service by service basis and billed in 15 minute increments.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Peer Support services. The agency's Mental Health and Substance Use fee schedule rate for Peer Support will be set as of July 1, 2025 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

This rate will be the same for quasi-governmental and private providers of community support service.

OPIOID TREATMENT PROGRAM (OTP)

When services are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's OTP rates on the Mental Health and Substance Use fee schedule is updated as of July 1, 2025, and will be effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

Effective for dates on or after October 1, 2020, services in this program are reimbursed per Supplement 2 to Attachment 4.19-B, page 1.

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NURSE MIDWIFE SERVICES

Payment for nurse-midwife services is made to the nurse-midwife or the physician with whom the nurse-midwife has a practice agreement; the physician is then responsible for payment to the nurse-midwife. Payment for nurse-midwife services is made at the lower of:

1. The provider's submitted charge; or
2. A percentage, determined by the Department, of the amount allowable under Item 5 of Attachment 4.19-B for the physician with whom the nurse-midwife has a practice agreement.

Nebraska Medicaid covers pre-natal care, delivery, and postpartum care as a "package" service. Auxiliary services, such as pre-natal classes and home visits, are not paid as separate line items.

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

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EXTENDED SERVICES TO PREGNANT WOMEN

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for extended services to pregnant women at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for extended services to pregnant women on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN FURNISHED DURING A PRESUMPTIVE ELIGIBILITY PERIOD

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a Medicaid-enrolled provider at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Ambulatory Surgical Center and Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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PAYMENT FOR PEDIATRIC OR FAMILY NURSE PRACTITIONERS

Payment for certified pediatric nurse practitioners or certified family nurse practitioners is made at the lower of:

1. The provider's submitted charge; or
2. A percentage, determined by the Department of Health and Human Services Finance and Support, of the amount allowable under the Nebraska Medicaid Practitioner Fee Schedule if the services was provided by a physician.

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

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## TRANSPORTATION SERVICES

For dates of service on or after May 1, 2011, Nebraska Medicaid pays for emergency and non-emergency medical transportation services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Transportation Fee Schedule in effect for that date of service.

Non-emergency medical transportation services are reimbursed using the Non-Emergency Transportation Services Fee Schedule and emergency medical transportation services are reimbursed using the Ambulance Services Fee Schedule.

In accordance with 42 CFR 440.170(a)(3)(ii - iii), Nebraska Medicaid covers medically necessary travel expenses for the client and the escort including transportation, meals, and lodging. Reimbursement is made to the provider of covered services warranting escort support (typically a hospital) for transportation, meals and lodging. The provider of services works with the escort and family to arrange reimbursement for travel, lodging, and meals for the escort. Reimbursement through the fee schedules above is not limited by a per diem amount.

Meals and lodging services are reimbursed based on per diem rates. The rates are reflected on the fee schedule as by report or rates not established. The per diem rates are determined based on the local market costs of mid-priced hotels and restaurants of the area in which the expenses occurred.

For meals and lodging, Nebraska Medicaid will pay the lower of:

1. The provider’s submitted charge; or
2. The average cost of the local market mid-priced hotels and restaurants of the area in which the expenses occurred.
    i. The local market is determined as mid-priced hotels and restaurants within ten (10) mile radius of the area in which the expense is to occur.
    ii. No fewer than five (5) restaurants and five (5) hotels of the local area will be used, unless the area as defined above does not have that many.
    iii. The average costs/rates are reviewed and adjusted as necessary. Each rate is adjusted if the difference is equal or greater than $5.00.
        a. The rates for in state providers are annually reviewed and adjusted as necessary as described in 2.iii.
        b. The rates for out-of-state providers through the prior-authorization request, are reviewed and adjusted as necessary as described in 2.iii.

Escort providers who are rendering non-emergency medical transportation services or escort-only services are enrolled as providers and reimbursed through the Non-Emergency Medical Transportation fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of non-emergency transportation services and emergency transportation services. The agency’s Non-Emergency Transportation Services and Ambulance Services Fee Schedule rates were set as of July 1, 2025, and are effective for services provided on or after that date. All rates are published on the agency’s website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedules for the specific program and year.

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PERSONAL CARE AIDE SERVICES

For services provided on or after July 1, 1998. Nebraska Medicaid pays for personal care aide services at the lower of:

1. The provider's submitted charge: or
2. The allowable amount for that procedure code the Nebraska Medicaid Care Aide Fee Schedule.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2025 and are effective for personal care aide services provided on or after that date. All rates are published on the agency's website at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Personal Assistance Services fee schedule for the specific program and year.

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FREESTANDING BIRTH CENTER SERVICES

Nebraska Medicaid providers of birthing center services are reimbursed based on a fee schedule as follows:

a. Payment for birthing center services provided by a participating, licensed birthing center is limited to the allowable rates established by Nebraska Medicaid.
b. The fee schedule established by Nebraska Medicaid is based upon a review of Medicaid fees paid by other states;
c. The birthing center and the birth attendant must bill separately for the services provided by each. The birthing center may bill only for facility services outlined elsewhere in this state plan.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of freestanding birthing center services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for freestanding birthing center services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Free Standing Birth Centers' fee schedule for the specific program and year.

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INTERPRETATION SERVICES

Nebraska Medicaid reimburses providers for sign language, oral interpretive, and translator services for limited and non-English speaking members and/or deaf or hard of hearing members, when these services are necessary and reasonable to communicate effectively with members in conjunction with another Medicaid-covered service.

Interpretation services can only be covered in conjunction with another covered Nebraska Medicaid service or medically necessary follow-up visit(s) to the initial covered service. To be reimbursable, the interpretation service must be provided by:

- A staff member of the Billing Provider;
- An individual/agency who is contracted with the Billing Provider
- An interpretation phone service contracted with the Billing Provider; or
- Equipment that provides translation and interpretation support, such as Communication Access Real-Time Translation (CART)

Providers must use the billing code designated by the Department when billing for reimbursement for interpreters for members with limited English proficiency (LEP) and communication services for people who are deaf or hard of hearing:

- Maximum units to be billed per Nebraska Medicaid service/service delivery date are 8 units. One unit is equivalent to 15 minutes of interpretation service.
    - Residential or facility-based providers may bill for additional units in excess of 8 units per day as deemed necessary during the covered healthcare service stay.

The agency's fee schedule rate was set as of July 1, 2025, and is effective for interpretation services provided on or after that date. All rates are published on the agency's website at https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-FeeSchedules.aspx. From the landing page, scroll down to the Interpretation Services fee schedule for the specific program and year.

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ii. The denominator of which is the hospital's total days (Worksheet S-3 Part I, Column 8, Lines 14, 16-18, and 32).

a. The quotient of:
   i. The numerator of which is the hospital's total outpatient charges (Worksheet C, Part 1, Column 7, Line 202), and
   ii. The denominator of which is the hospital's total charges (Worksheet C, Part 1, Column 8, Line 202).

A. Determining Supplemental Direct Graduate Medical Education Payments. The amount of direct GME payments for eligible teaching hospitals will be determined as follows:
   1. Designated UNMC Affiliated Teaching Hospitals shall receive a payment that is the product of 1.15 and the sum of the Hospital's Annualized Medicaid Intern Resident Cost as calculated in subsection (B.)(1.) of this section.
   2. All Other Eligible Teaching Hospitals shall receive a payment that is the product of 0.40 and the sum of the Hospital's Annualized Medicaid Intern Resident Cost as calculated in subsection (B.)(1.) of this section.

B. Indirect Graduate Medical Education Definitions
   1. Residents - The number of full-time equivalent (FTE) interns and residents in approved training programs for an eligible hospital as reported on the most recent CMS Form 2552, Worksheet E, Part A, Column 1, Line 10, plus Worksheet E, Part A, Column 1, Line 11. For eligible hospitals excluded from the Medicare prospective payment systems under 42 CFR 412.23, the number of FTE interns and residents in approved training programs is the FTEs as reported on the most recent CMS Form 2552, Worksheet E-4, Column 1, Line 6.
   2. Beds - The total number of bed days available as reported on the most recent CMS Form 2552, Worksheet E, Part A, Column 1, Line 4. For eligible hospitals classified as excluded from the Medicare prospective payment systems under 42 CFR 412.23, beds days available is determined by dividing the number of bed days available from CMS Form 2552 Worksheet S-3, Part I, Column 2, Line 14 by the number of days in the cost reporting period.

C. Methodology for Determining Indirect Graduate Medical Education Payments.
   The amount of indirect GME payments for eligible teaching hospitals is calculated using the hospital's ratio residents to beds and Medicaid payments as follows:
   1. Calculate each hospital's indirect medical education percentage =2.27 x ((1 + (Residents/Beds))^0.405 – 1)
   2. Multiply the results computed in (E.) (1.) of this subsection by the hospital's Medicaid outpatient payments.
   3. Designated UNMC Affiliated Teaching Hospitals shall receive a payment that is the product of (E.)(2.) and 1.15.
   4. All Other Eligible Teaching Hospitals shall receive a payment that is the product of (E.)(2.) and 0.40.